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# REQUEST FOR MEDICAL RECORDS

Name of Person Requesting Records: ___________________________________________________________

Relationship to Patient(s): _______________________________________ Contact Phone #: ___________________

Patient's Name: _______________________________________________ Date of Birth: ______________________

Patient's Name: _______________________________________________ Date of Birth: ______________________

Patient's Name: _______________________________________________ Date of Birth: ______________________

Patient's Name: _______________________________________________ Date of Birth: ______________________

**I, hereby authorize Urbana Pediatric, LLC**

☐ to ***release*** copies of medical records to: ☐ to ***obtain*** copies of medical records from:

___________________________________________________________________________
**Name/Organization**

___________________________________________________________________________
**Address**

________________________________________ ____________________________________
**Phone** **Fax**

**Reason for release of records:**

- ☐ Transferring practices
- ☐ Other: ________________________________________________

**Information to be released:**

- ☐ Complete medical record
- ☐ Immunization record
- ☐ Labs
- ☐ Other: _________________________________________________

I hereby authorize the release of medical records for the patient(s) above. This authorization will expire 1 year from the date of signature below. I understand that I may revoke this authorization by submitting written notice of revocation to Urbana Pediatrics, LLC.

_______________________________________________________ __________________________
Signature of Parent/Guardian or Patient (if 18 years or older) Date