



529 Highway 35  
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### Records Release Authorization

I authorize and request the release of my child/children's medical records.

Child/Children's Name(s): \_\_\_\_\_

Child/Children's Date of Birth: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Signature of Patient (if over the age of 18)

There is a charge of \$1.00 per page with a maximum of \$20.00 per child and a maximum of \$60.00 per family. You will only be billed when the record review is complete and ready to be mailed. Records cannot be released until payment is made. For the most efficient release process, please use a credit card.

TYPE OF CARD \_\_\_\_\_

Card # \_\_\_\_\_

Exp. Date \_\_\_\_\_ Security No. \_\_\_\_\_

\_\_\_\_\_  
Signature

Please select how you would like your records to be transferred:

- I will pick up my records. Please call this number when ready: \_\_\_\_\_
- Please, mail my records to the following address: (Additional shipping charges might apply).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reason for transfer: (If due to insurance change, please indicate new plan). \_\_\_\_\_

Thank you,  
Middletown Pediatrics