Pediatric Associates, Inc.

If paying by credit/debit card $20.00 will be applied to the card indicated: \_\_Discover \_\_\_Mastercard \_\_Visa

*Records will not be released until payment is received.*

Card#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Exp. Date:\_\_\_\_\_\_/\_\_\_\_\_\_ Authorization Code:\_\_\_\_\_\_\_\_

*Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_/\_\_\_/\_\_\_*

Records Release Authorization

Date:\_\_\_\_/\_\_\_\_/\_\_\_\_

I hereby authorize and request the release of information contained in the medical records of:

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_/\_\_\_\_/\_\_\_\_

(please **PRINT** Last name, First name)

*Release From:* Pediatric Associates, Inc.

7910 W. Jefferson Blvd.

Ste. 201

Fort Wayne, IN 46804

260-436-3789

Release To (Name of physician &/or group): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(please print)**

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

(street address)

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

(city, state, zip)

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

(phone#)

The purpose for disclosure:

* Change of doctor due to age
* Seeing a specialist
* Moving out of state/city
* Prefer a physician closer to home/work
* Disagree with office policies/Unhappy with practice-please explain on back of form
* Insurance change
* Personal use
* Missed Appointments

*I, the undersigned, understand that I may revoke this authorization at any time, in writing, but the request shall remain until revoked or upon the expiration of (60) days, whichever occurs first, except to the extent that action has been taken thereon. I understand that I am giving permission to release medical information which may include treatment for physical and/or emotional illness, pregnancy, genetic testing, communicable diseases, alcohol or drug abuse treatment, and/or HIV, AIDS, or AIDS-related information. I understand that the medical records will be mailed on an unencrypted USB unless otherwise specified above.*

Patient/Legal Guardian:

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_/\_\_\_\_/\_\_\_\_

**Printed** Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(please print-street address, city, state, zip)

Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*Medical records are legal documents, therefore owned by Pediatric Associates, Inc. Charges for copies of these documents shall be in accordance with the Indiana code 760 IAC 1-71-3 effective November 2005, which states as follows:*

*A1.* ***$20.00-Electronic copy (entire family)***

*A2. If a person insists that records be provided within 2 working days, an additional* ***$10.00*** *fee will be assessed.*

*B1. Minimum $20.00 fee for paper copies (includes pages 1-10)*

*B2. .50 Per page (pages11-50)*

*B3. .25 Per page (for pages 51 and up)*

*B4. Postage fee applicable (PAI waives the postage fee as a courtesy)*

**Office use only:** *PAI associate must date and initial every line.*

Release Rec’d on by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on \_\_\_\_/\_\_\_\_/\_\_\_\_ Pymt Rec’d by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_on \_\_\_\_/\_\_\_\_/\_\_\_\_

Records mailed by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_on \_\_\_\_/\_\_\_\_/\_\_\_\_ Family deactivated and notes made on each account by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SCAN THIS RELEASE FORM FIRST AND THEN THE PATIENT RECORDS**.