Terry C. Childers, **MD, FAAP**
Margaret E. Goodwin, **MD, FAAP**
Mark T. Jackson, **MD, FAAP**

Carol A. Long, **MD, FAAP**
Brian P. O'Donnell, **MD, FAAP**
Karen J. Walter, **MD, FAAP**

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MEDICAL RECORDS RELEASE

Patient Name: ____ DOB:____________________

Patient Address: ____

Contact Phone Number: _________________________ Alternate Contact# _______________

Please release the above named person's medical records to: (FILL OUT COMPLETELY)

Person, Physician or Practice Name: ____

Address: ____

City/State/Zip: ____

Phone #: _______________________________ Fax#: ___________________________________

Please obtain the above named person's medical records from: (FILL OUT COMPLETELY)

Person, Physician, and Practice Name: ____

Address: ____

City/State/Zip: ____

Phone#:_____________________________ Fax# _______________________________________

Purpose for request ___ Transfer of Care ____ Personal ____ Other: ___________

Type of records being requested: ____ Entire Medical Record + other MD/Provider records

Other: (please specify) ____

Note: Medical record are faxed in cases of medical necessity (records to another medical provider) only. Mountain Area Pediatric Associates, P.A. will not be able to accommodate any request for records to be fax to any personal fax, non-medical business fax, school or daycare.

Mountain Area Pediatric Associates, P.A and its employees or agents are released from legal responsibility for the release of the above information to the extent indicated and authorized herein.

ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT(S) IS PROHIBITIED EXCEPT WHEN IMPLICIT IN THE PURPOSES OF THIS DISCLOSURE.

Parent or Legal Guardian Name: ______________________________________ Relationship to patient: ___________________

Parent or Legal Signature: ____ Date: ________________________