Terry C. Childers, **MD, FAAP**
Kiersten S. Derby, **MD, MPH, FAAP**
Margaret E. Goodwin, **MD, FAAP**

Mark T. Jackson, **MD, FAAP**
Brian P. O'Donnell, **MD, FAAP**
Karen J. Walter, **MD, FAAP**

MOUNTAIN AREA PEDIATRICS

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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)
*One complimentary copy of patient chart will be sent upon request. All additional copies will include a charge. Payment must be received before additional requests will be fulfilled.

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 faxed 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: _____