larchmont pediatrics
pediatric and adolescent medicine

Medical Records Request

I hereby authorize the transfer of my or my child's health information as described below.
I understand that a photocopy or fax of this authorization is a valid as the original.

Patient Name: _____

Date of Birth: _____/_____/_____

Address: _____

_____

Phone Number:_____

Persons/organizations authorized to release information

_____

_____

_____

Persons/organizations authorized to receive information

_____

_____

_____

Information that may be used/disclosed:

Records of all visits_____	Records of specific visits____	Discharge Summary____
History/Physical____	Consultation Reports____	Problem list____
Progress Notes ____	Immunization Records____	Medication Records ____
Laboratory Reports____	X-Ray,MRI, CT Reports ____	Hepatitis Information____
Operative Reports_____	Echo, Stress Test, Holters_____	EKG Reports_____
Mental Health_____	AIDS/HIV Information_____	Alcohol/Drug Abuse Treatment_____
Entire Medical Record_____	HEADSS Exam _____ (Teen Confidential History)	Other_____

Signature of Patient or Representative

_____ Date ____/____/____

Printed Name of Patient or Patient's Representative

Relationship to Patient

_____ _____

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