Janet McCormick, M.D., F.A.A.P.
Lorna McFarland, M.D., F.A.A.P.
Eric Lau, M.D., F.A.A.P.
Kirat Grewal, M.D., F.A.A.P.
Jill Gaoghagan, M.D., F.A.A.P.
Gin Lee-Hong, M.D., F.A.A.P.
Eddie Quan, M.D., F.A.A.P.
Janet Chou, M.D., F.A.A.P.

Medical Records Request and Release

For: ____ Date of Birth______________
____ Date of Birth______________
____ Date of Birth______________

1. I hereby authorize that the medical records for the above individual(s):

(***select one***)

[ ] be ***SENT TO*** Columbia Pediatrics Medical Group, Inc., ***FROM*** the following Agent.

[ ] be ***SENT BY*** Columbia Pediatrics Medical Group, Inc., ***TO*** the following Agent.

Agent Name: ____
Street Address: ____
City/State/ZIP: ____
Contact Phone: ____________________ Fax Number:__________________

2. Please send:

[ ] All Medical Records
[ ] Medical Summaries
[ ] Other:____

For the purpose of:

[ ] Continuing Medical Care
[ ] Other:____

I understand that I have a right to receive a copy of this authorization upon my request and that a fee is charged to me for these medical records. I acknowledge that payment should accompany this request.

____
Print Name, or Name of Parent/Guardian of Patient who is a minor

Patient Street Address: ______________________
Patient City/State/ZIP: ______________________
Patient Phone Number: ______________________

____
Signature Date

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