COLUMBIA PEDIATRICS
MEDICAL GROUP, INC.
www.columbiapediatrics.com

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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

_____
Signature Date

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