BUCKINGHAM PEDIATRICS

PH# 215-794-3305/FAX 215-794-9642

P.O. BOX 665 BUCKINGHAM, PA 18912

REQUEST FOR RELEASE OF MEDICAL RECORDS

I hereby authorize Buckingham Pediatrics to disclose the medical records of the below named patient(s). An authorized signature from the adult patient, a parent or legal guardian **must** appear in the signature area of this form before records will be released. I further authorize the disclosure of mental health, drug abuse, STD, HIV and/or AIDS information.

Patients whose records are to be released:

1.____D.O.B._______/_______/_______

2.____D.O.B._______/_______/_______

3.____D.O.B._______/______/________

4.____D.O.B._______/______/________

5.____D.O.B._______/______/________

Signature_____________________________________**Date**___________**Relationship**______________

__________The Medical records are to be picked up and signed for at: BUCKINGHAM PEDIATRICS

__________Medical record copies are to be mailed to:

Name:____PH#______________________________

Address:____

City____STATE_____________ZIP CODE_____________

MEDICAL RECORDS COPYING

Dear Parent, Guardian or Patient,

Buckingham Pediatrics contracts with Accudocs, a medical record copying service, to process your request for copying and transferring your medical records**. $20.00** per patient chart is the flat fee. Payment is calculated by number of patient chart requests: **example 1 chart $20.00 , 2 charts $40 etc.**

Payment is required upon request; please check with front desk regarding payment.

Upon receipt of request and payment, copies will be sent in approximately 10 to 14 business days.

Complete the information requested, date and sign.

Number of Medical Charts information requested___________

Check #_______________/Cash Amount $_________________/Credit Card_______________________

Signature:_____________________________**Date:**_________________

IF YOU ARE NOT LEAVING OUR PRACTICE, PLEASE ADVISE ACCORDINGLY