

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. \$25.00 per patient chart is the flat fee. Payment is calculated by number of patient chart requests: example 1 chart \$25.00 , 2 charts \$50 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