Primary Pediatrics
Authorization to Release Health Information

We are required by applicable federal and state law to maintain the privacy of your health information until you authorize us to disclose your protected medical records.

Please release the following information to:
❒School/College
❒Day Care
❒Camp
❒Other _____

- There is a ten dollar ($10) fee incurred for processing all forms and letter writing requests.
- **All patients must have a well care physical on record within one calendar year before any forms can be processed. No Exceptions! We cannot deem a patient healthy without an examination.**
- Please allow three business days to complete your request.
- **For rush or same day turnaround of forms, there is an additional rush fee of $10 (for a total of $20).**
- We do not mail or fax forms, but you may provide a self-addressed stamped envelope for mailing.*

Please note: *Duplications are not added to the patient's medical records.*

By signing below, I give Primary Pediatrics permission to release protected health information regarding

_____ _____
Print Patient name D.O.B

_____ _____
Print (parent) name Signature parent/guardian

_____
*Please list a telephone number to call when forms are completed and ready for pick up.

_____Initials of employee reviewing the forms and chart for well check physical _____
DATE

❍NOT PAID **❍PAID IN ADVANCE**

Method of payment:

__Cash receipt number_____
__Credit Card invoice number _____
__Check number _____