Authorization to Release Medical Records

Child's name: _____ **Date of birth:** _____

Direction of release (check one):

☐ SEND my child's records FROM Franklin Pediatric Associates TO: _____
_____

☐ GET my child's records FOR Franklin Pediatric Associates FROM: _____
_____

Name of other office/person: _____

Address / fax / portal: _____

Records to include: ☐ Entire chart ☐ Vaccines only

☐ Dates: _____ to _____ ☐ Other: _____

Note: Records sent to your child's new primary care doctor are free. Fees for other requests follow Pennsylvania's medical records fee schedule and federal law.

This authorization expires 1 year from the date signed unless I cancel it sooner in writing. I may cancel at any time, except for records already sent

Parent/Guardian signature _____

Printed name: _____

Relationship to child: _____

Date: _____