RELEASE OF RECORDS

THE PEDIATRIC CENTER
3430 WASHINGTON PARKWAY
IDAHO FALLS ID 83404
208-523-3060 FAX 208-523-0028
EMAIL ADDRESS: medrecs@mypediatriccenter.com (no reply)

$15 CHARGE FOR EACH SET OF MEDICAL RECORDS
$5 CHARGE FOR EACH IMMUNIZATION CARD
RECORDS SENT PROVIDER TO PROVIDER ARE COMPLIMENTARY

Date: _____
Patient Name: _____
Date of Birth: _____

Records that need to be released: (please circle)

Labs Immunizations Imaging

Growth charts Chart notes All records

Agency or Provider records are being ***released from***:
Name: _____
Address: _____
Phone number: _____ **Fax number:** _____

Agency or Provider records are being ***released to***:
Name: _____
Address: _____
Phone number: _____ **Fax number:** _____
Email address: _____

If records are being released to you, how would you like to receive them? (Please circle)

Pickup Postal Service Email: _____

I hereby give consent to release my child's medical records, duration of this consent is good for one year from the date signed (please initial)_____

Signature of Parent or Guardian: _____

As the person signing this consent, I understand that I am giving my permission to the above named provider or third party, for the disclosure of confidential health care records. I also understand that I have the right to revoke this consent, but my revocation is not effective until delivered in writing to the person who is in the possession of my records. A copy of this consent will be included with my original records. The person who recieves the records to which this consent pertains may not release them to anyoen without my separate written consent; unless such recipient is a provider who makes a disclosure as permitted by law.