RELEASE OF RECORDS

THE PEDIATRIC CENTER
3430 WASHINGTON PKWY
IDAHO FALLS, ID 83404
208-523-3060 FAX 208-523-0028
********EMAIL ADDRESS: MEDRECS@CABLEONE.NET ********

$15 CHARGE FOR EACH SET OF MEDICAL RECORDS
$5 CHARGE FOR EACH IMMUNIZATION RECORD
NO CHARGE IF SENT FROM PROVIDER TO PROVIDER

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

Records that need to be released: _____

Person, Agency or Provider records are being **released from**:

Name: _____
Address: _____
Phone and Fax: _____

Previous Agency or Provider records are being **released to**:

Name: _____
Address: _____
Phone and Fax: _____
If records are being released to you, how would you like to receive them?

E-mail:_____ ☐ Fax ☐ Postal Service

I hereby give consent to release my child's medical records
Duration of Consent is good for 1 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 that 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 receives the records to which this consent pertain may not release them to anyone without my separate written consent unless such recipient is a provider who makes a disclosure as permitted by law.