

## REQUEST FOR MEDICAL RECORDS

**Patient Information:**

Patient Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Parent/Guardian Name (Person making request): \_\_\_\_\_  
Patient Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Release Information To:**

I hereby Authorize Piller Child Development, LLC to release my medical record information to:

Hold for Patient Pick-up       Email To: \_\_\_\_\_  
 Mail Copies To:  
Name/Facility: \_\_\_\_\_ Attention: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Fax: \_\_\_\_\_

**Specific Information to be Released:**

Date(s) of Service: \_\_\_\_\_

Pertinent Information\* (includes evaluation and/or progress reports, treatment notes)  
 Evaluation  Discharge Summary  Progress Reports  
 Daily Treatment Notes  Intake form  Physician Referral  
 Complete Records: Date of Visit \_\_\_\_\_  Other (specify): \_\_\_\_\_  
 Paper Records

\*Piller Child Development, LLC will provide up to 10 pages of your record per calendar year at no charge (only for patient care requests). Any additional pages will be provided at \$.30 a page plus a processing fee of \$35/50 pages for paper records. Postage and handling will be added for mail requests.

**My Rights:**

I understand that this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization.

I understand that I may revoke this authorization at any time, with some exceptions, that being to the extent that Piller Child Development has acted on this authorization prior to the date we received the letter to revoke authorization.

To revoke my authorization, I must submit a written request to Piller Child Development.

I am entitled to receive a copy of this Authorization.

**Notice to Recipient:**

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information without express written consent of the person to whom it pertains. The information being released will no longer be protected from re-disclosure by recipient.

This authorization will expire within 60 days unless I note here a specific date, event or condition.

**Parent/Legal Health Care Representative Signature**

**Date**

**Released by**

**ID Used**

**Date**