PILLER
CHILD
DEVELOPMENT

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:
❑ Mail Copies To: ❑ Hold for Patient Pick-up
Name/Facility: _____ Attention: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____ Fax: _____
Purpose of Request: ❑ Personal ❑ Continuing Care ❑ Legal ❑ Other: _____

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 $.25 a page plus a processing fee of $15 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**