PEDIATRIC GASTROENTEROLOGY ASSOCIATES
2577 Samaritan Drive, Suite 815
San Jose, California 95124
Phone (408) 358-3573
Fax (408) 356-2888

REQUEST FOR THE RELEASE OF MEDICAL RECORDS

PATIENT NAME:________________________________ Date of Birth:___________

I authorize Pediatric Gastroenterology Associates to release to:

____

____

____

____

copies of____________________________________'s private health information.
(your child's name)

I understand that a fee of at least $15 will be charged for this service. The Pediatric GI staff will inform me of the actual cost upon reviewing my child's medical record.

Please copy: ____________all records from all dates of service

____________all records for specific dates:_____________ to ___________

____________partial records as specified:__________________________

____

Additional comments or instructions:____

______These records are to be faxed (*additional fee*) to ( ) ______________________

______These records are to be mailed to the above-named person/physician.

______These records will be picked up by (name)____________________

____Date of Request___________
Signature of parent or guardian only

Your request will be processed upon receipt of your written request and payment and may take up to 2 weeks.

FOR OFFICE USE ONLY: *FEE*______________ *DATE RECEIVED*_________________

*DATE RECORDS SENT*_____________

*SENT BY*________________________