Caring for the
Next Generation

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Medical Records Release Form

Patient Name:____Date of Birth:________________

Person requesting records:________________________________Relationship:____________________

Release my protected health information to/from Heritage Pediatrics to/from the following person(s)/entity:

Name: ___________________________________ OR Fax #:________________________

Street:____________________________________

City: ____________________________________

State:___________Zip:______________________

I DO__________I do NOT__________ give permission for these records to be faxed to the above entity.

Dates of service to be released:

- ☐ Any and all dates of service
- ☐ Other: ____

Records to be released:

- ☐ Growth Charts
- ☐ Vaccine History
- ☐ Pertinent Lab Results
- ☐ Pertinent Medical Records

Purpose of disclosure:

- ☐ Referral or Continuity of Care
- ☐ Transfer of care
- ☐ Shot Record
- ☐ Other:____

By signing this form, I have the parental authority to authorize access, and give permission for Heritage Pediatrics to release any and all confidential health information about above child, by releasing a copy of their medical records, or a summary or narrative of their protected health information, to the person(s) or entity listed above.

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Signature Date