Olive Branch Pediatrics

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Request for Release of Medical Records

Patient Name(s): ____

Date(s) of Birth: ____

I hereby authorize Olive Branch Pediatrics, PLLC to obtain / receive a copy of the medical record(s) of the above named patient(s) from:

Sender:	Recipient:
☐ Olive Branch Pediatrics, PLLC	☐ Olive Branch Pediatrics, PLLC
Name: _______________________________	Name: _________________________________
Address: _______________________________	Address: _________________________________
_______________________________	_________________________________
Phone: _______________________________	Phone: _________________________________
Fax: _______________________________	Fax: _________________________________

If only a certain portion of the medical record should be sent, please specify below:

____

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Please note that, by law, a signature is needed from patients over the age of 13 for records related to mental health treatment and substance abuse and from patients over the age of 14 for records related to sexually transmitted diseases, birth control, and pregnancy related services. In addition, a $50 fee will be charged for each copy of the medical record. Please also allow five to ten business days for the request to be completed.

Signature of Patient: ____

Signature of Parent/Guardian: ____

Date: ____