Affiliated with

CHILDREN'S & WOMEN'S PHYSICIANS OF WESTCHESTER, LLP

Medical Release Form

Patient Name: ___________________________
Date of Birth: ____________________________
Patient Address: __________________________
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We will provide you with access to your protected health information in the form or format you request. Please indicate the form or format you desire. We will charge a fee for the copies you requested. Our fee is governed by law and is $.75 per page, plus postage. We will advise you in advance of the fee for the summary. Please allow at least 2 week for copies to be ready.

I, ___________________________ (Name of Parent or Guardian) am hereby requesting a copy of the medical records of ___________________________ (Name of the patient) to be released to me.

I want a copy of (please choose one):
_____ The entire medical record.
_____ A summary of patient's last physical exam.

I acknowledge that the fax of my signature will be accepted as original:

___________________________ ________________________
Signature of Parent or Guardian Date

NOTE: Under law, there are certain cases where we cannot release some of your protected health information for copying. We will advise you if this occurs in your case and your rights.

FOR PRACTICE USE ONLY:
Date of copy provided: ___________________ Provided by: _______________________
Fee for copy provided: ___________________