Durant Road Pediatrics
Medical Records Release Form

Patient Name: _____ **DOB:** __/__/____

Address: _____

Home Phone #: _(___)____-_____ **Cell Phone #:** _(___)____-_____

Transfer to DRP

I authorize:

Name: _____

Address: _____

_____

Tel #: _(___)____-_____

Fax #: _(___)____-_____

to release medical records to:

Durant Road Pediatrics
10880 Durant Road, Suite 215
Raleigh, NC 27614
Tel #: (919) 205-4410
Fax #: (984) 200-2821

Transfer from DRP

I authorize:

Durant Road Pediatrics
10880 Durant Road, Suite 215
Raleigh, NC 27614
Tel #: (919) 205-4410
Fax #: (984) 200-2821

to release medical records to:

Name: _____

Address: _____

_____

Tel #: _(___)____-_____

Fax #: _(___)____-_____

Reason for release:

1. Transfer to another practice because of move / insurance change / age / other (please specify)
2. Medical follow up with specialist
3. Legal
4. Copy for self

Cost of medical records is $20 per child. Please allow 2-3 weeks to process this request.

Medical summary will include: immunization record, growth charts, problem list, allergies, last check up and sick appointment.

I understand that in the event that I was treated for drug or alcohol abuse, psychiatric/mental health issues, HIV/AIDS, this information will be included as part of my medical record unless specifically stated/declined by me.

I hereby authorize the release of medical records for each child as listed below:

1. _____ 2. _____

3. _____ 4. _____

Signature: _____ Date: __/__/____

Printed Name: _____