

REQUEST FOR MEDICAL RECORDS

Patient Name(s) _____ Date of Birth _____

Physician Name _____

Records should be delivered to:

Information of Record Requested _____

I understand that I have the right to access my/my child(ren)'s medical records in accordance with the law and the policies of Richmond Pediatric Associates. I understand that Richmond Pediatrics may charge me for copies of my medical records, and I have been provided a fee schedule.

I understand that Richmond Pediatrics has the right to deny my access to the records in certain circumstances in accordance with the law. If Richmond Pediatrics denies me access to my/my child(ren)'s medical information, I understand it will provide me with the reasons for the denial in writing and describe whether I have the right to have a review of the denial performed by a licensed health care professional.

Please note that information disclosed pursuant to the request is no longer under the control of Richmond Pediatric Associates and may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Signature of Patient (if over 18) _____ Date _____

Patient Representative _____ Date _____

Relationship to Patient _____