Mt. Washington Pediatrics
Patient Release of Medical Information Request

Date: _____

Patient Name: _____ Date of Birth: _____

Information to be released from: _____

Information to be released to: Mt Washington Pediatrics Fax: 833-450-5446

Information Requested (check all that apply):

_____Patient's Entire Medical Record

_____H&P and/or Consultation note

_____Progress Notes for the last _____ visits / months

_____Discharge Summary

_____Lab Results

_____X-ray Results

_____ Procedure Notes

_____ Operative Summary

_____Other:

I hereby request that the above information be provided to the person or business listed.

Signature of Patient/Requestor* _____

*If signed by someone other than the patient, please provide the following information:

Name of Requestor_____Relationship to Patient _____