THH PEDIATRICS
TENDER HEARTS & HANDS

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Request for Release of Medical Records

Date of Request: _____

Name(s) of Patient(s): _____ DOB _____

_____ DOB _____

_____ DOB _____

I hereby authorize Drs. Takai, Hoover, Hsu, and Associates to release medical records on the above patient(s) _____ Date _____

Signature of Parent or Legal Guardian

How are the records going to be obtained? Circle One PICK UP MAILED

WE DO NOT FAX RECORDS!!!

Mailing Address:

_____

_____

_____

Contact Phone Number: _____

Reason for Leaving Practice: _____

Records will include:
Problem list and pertinent office visit
Health maintenance sheets
Growth Chart
Immunization records
Consultant reports
Pertinent lab work and diagnostic studies

RECORDS NORMALLY TAKE 7-10 DAYS TO COMPLETE

----------OFFICE USE ONLY----------

Date Payment Received: _____ Date Copied _____

Method of Payment Cash ___ Check ___ Charge ___ Needs to Pay __