

Westchester Park Pediatrics

222 Westchester Avenue, Suite 202

White Plains, New York 10604

Phone: 914-761-1717 ; Fax 914-761-1711

Patient Name: _____

Patient Address: _____

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.

I _____ (Name of parent or guardian)

am hereby requesting a copy of the medical records of _____

_____ (Name of patient or patients)

to be released to me. I want a copy of (please choose one):

_____ The entire medical record

_____ A summary sheet of the medical record

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 of your rights.

FOR PRACTICE USE ONLY:

Date copy provided: _____ Provided by: _____

Fee for copy provided: _____