ALL CARE PEDIATRICS PA

90 Millburn Avenue, Suite 101
Millburn, NJ 07041
Tel. # 973-378-7990
Fax # 973-378-7991

OUTGOING RECORDS RELEASE AUTHORIZATION

I, _____, legal guardian of patient(s) listed below, hereby request and authorize you to release the records of:

Name _____ DOB _____

Name _____ DOB _____

Name _____ DOB _____

Name _____ DOB _____

The information to be released will cover the time period from _____ to _____

- ☐ Immunizations only (Inactive patients only; $10 5-7 day turnaround, $15 3-5 day turnaround)
- ☐ Entire Record Include medical records from previous physician (cannot email)
- ☐ Specialist Reports _____
- ☐ Other: _____
- ☐ Exception: I do NOT give permission to release: _____

Leaving the practice? YES NO Reason for leaving: _____

If moving new address: _____

Delivery Method: Pick up by: _____

Fax to: _____ Fax # _____

Email: _____ (Immunization Records only)

Mail to:

Name: _____

Address: _____

_____

Record Release Fee: **$20 each patient for the first two patients, $10 for each additional patient.**
We accept cash, check and all major credit cards. You may also visit our website to pay online.

I understand that requests for Entire Records will take up to ten business days to complete.
The record release process will begin once payment is received.

_____ _____ _____
Signature of Responsible Party Date Telephone Number

For Internal Purpose Only:
Receiving Staff Initials: _____ Date: _____

Manager's Initial _____ Date _____

Pick-Up date: _____
Faxed date: _____
Emailed date: _____
Mailed date: _____