ALEXIUS M. BISHOP, M.D., P.S.C.
PEDIATRIC AND ADOLESCENT MEDICINE

REQUEST FOR RELEASE OF MEDICAL RECORDS

Reason for request:
_____ Transfer
_____ Moving
_____ Insurance
_____ Unhappy
_____ Following Doctor
_____ Other:_____

Fill in complete name and address of Doctor, Specialist or person receiving records:

Name:_____

Address:_____

_____ _____ _____
City State Zip Code

I HEREBY REQUEST MEDICAL RECORDS BE RELEASED TO ABOVE ADDRESS.

Parent/Guardian Signature_____ Date:_____

Forwarding Address:_____

_____

_____ _____
Telephone Number Cell Number

Patient(s) Name: Date of Birth

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

I understand that as of today's date, there is a balance of $_____ on my account. This balance is due in full within thirty (30) days. If left unpaid, my account will be forwarded to a collection agency with instructions to collect the balance in full. I also understand I am entitled to one free copy of medical records and any future requests will incur a charge.

*If patient is over the age of 18, I allow _____ to receive my records.

Received by:_____ Date:_____

COPIED BY:_____ DATE:_____ CALLED:_____ _____ _____

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