Shore Care Pediatrics

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Record Release Authorization

I authorize and request the release of my child / children's medical records.

Child / Childrens Name(s) _____

Child / Childrens Dates of Birth(s) _____

_____
Signature of Parent

_____
Signature of Patient (if over 18)

There is a charge of $1.00 per page up to a maximum of $100 per child. You will only be billed when the record review is complete and records are ready to be mailed. Records cannot be released until a payment is made. For the most efficient release process, please use a credit card.

Type of Card _____

Card # _____

Expiration _____

Security No: _____

Signature _____

Reason for transfer: _____

If due to insurance please indicate name of plan: _____

Please call this number when the record review is complete and the records are ready for pick-up:

_____

Thank you,
Shore Care Pediatrics