IMA PEDIATRICS

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Integrated Medicine Alliance

An office of Dr. Brendan Mulholland

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MEDICAL RECORD REQUEST

Please send well visits, lab results & immunization records.

Patient Name: _______________________________ DOB:__________

Street Address: ____

Phone Number:____

Doctor/Facility information:

Name of Practice/Dr:____

Street Address:____

Phone Number:_______________________ Fax Number:____________________

I hereby authorize the office/facility indicated above to release copies of my medical records to the requesting office/facility.

Print (Parent/Legal Guardian)

____

Sign____ Date: ____________

(Parent/Legal Guardian Signature)

I authorize the release of any, and all of my medical records; including records concerning psychiatric treatment, drug and alcohol abuse treatment, Human Immunodeficiency Virus (HIV) infections and AIDS. This will include any test results and treatments, as well as counseling records. I understand that my records are privileged and confidential in status. I am waiving that status for the purpose stated above. I release and hold Dr. Brendan Mulholland, his practice and employees for all liability that may arise complying with this authorization. This authorization shall remain in force for 90 days. I understand the policy regarding changes to me associated with this request for medical records and agree to pay the amount indicated by the staff based on the number of pages of records provided. Please note: There is no charge for records transferred to another physician.