PEDIATRIC ASSOCIATES, P. A.

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Medical Records

The physicians and staff of Pediatric Associates often receive questions regarding patients' access to medical records. We have consulted the Board of Medical Practice Dover, Delaware and their recommendations are as follows:

In the state of Delaware, medical records and all of the papers contained within are the property of Pediatric Associates, P.A. Custodial parents, legal guardians, and patients of legal age are the only parties legally eligible to access any medical records. An appointment for review of any record will be scheduled in consultation with one of our physicians.

Our staff will be happy to prepare copies of any records for forwarding to another physician after receiving a written request from the custodial parent, legal guardian, or patient of legal age. Please note all patients of legal age are required by law to request their own records. Unfortunately, we will no longer be able to provide this service free of charge. Like most physician practices state wide, **a charge of $20.00 per family chart is required** with the written request to cover the expense of staff time and supplies. However, a record of immunization dates can be provided to you or another physician at no cost. We request two weeks for completing our process.

Our Medical Records Coordinator is available to answer questions should you need further assistance (302) 368-8612. You can also receive detailed information by calling the Board of Medical Practice in Dover, Delaware at 302-739-4522 extensions 203, 211, or 213.

Patient Transfer Request Form

By signing this document, I authorize Pediatric Associates, P.A. to transfer protected health information about my child to the party listed below.

Release To:

_____
Name

_____
Address

Please select items to be released:
___All records ___Date Range ____/____/____ to ____/____/____

Reason for Transfer:
( ) Change of Pediatrician

( ) Moved

( ) Location / Distance

( ) Age ____

( ) Dissatisfied Why? _____

( ) Other _____

When my information is disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. This form has been fully explained and I certify that I understand its content.

Authorization:

_____
_____
Patient Name Date of Birth

_____
_____
Patient Name Date of Birth

_____
_____
Patient Name Date of Birth

If a patient is 18 years or older, patient signature is required by law! Adult patients must complete their own form.

Processing of request will begin upon receipt of this completed form and $20.00 processing fee.

_____
Signature of Authorized Person Relationship to Patient Date