Dover Pediatrics, PLLC

NEW PATIENTS REQUEST to OBTAIN Medical Records

Patient Name: _____ **Date of Birth:**_____

□ Request Medical Records From:

Name:
Address:
City, State, Zip
Phone Number: ***Fax Number:***

MAIL RECORDS TO:

DOVER PEDIATRICS
17 OLD ROLLINSFORD RD
Suite 5
DOVER NH, 03820

I, _____hereby request a copy of the Medical Record for the patient listed above.

- **Relationship to Patient: □ *SELF* □ PARENT □ GUARDIAN □ OTHER: _____**

Indicate legal relationship to patient

Disclose and Provide a copy of the following Records

Please Check All that Apply:

□ Well Visits □ Office Visits □ Immunizations □ Medication List □ Lab/Radiology Results □ Drug/Alcohol Abuse

□ Mental Health Treatment □ Genetic Testing □ HIV Test Results or Status

□ Other_____

□ *Provide a copy of records from Date Range:_____ to_____ only.*

- **I understand I may inspect or obtain a copy of the protected health information described by this authorization.**
- **A nominal fee may be charged for the labor of copying, whether in paper or fax form, and supplies for creating a paper copy as permitted by law.**
- **This authorization becomes effective as dated and shall expire one (1) year from signature date**
- **I understand I have the right to withdraw my authorization at any time except to the extent that action has been taken in reliance on this authorization.**
- **I understand if I revoke this authorization, I must do so in writing and present my written revocation to the privacy officer of Dover Pediatrics.**
- **I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient, and if so, may not be subject to federal or state law protecting its confidentiality.**
- **I understand that Medical Records released pursuant to this authorization may include records generated by another healthcare provider or facility.**

_____ _____

Requestor's Signature ***Date***