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Southside Pediatrics Inc.

Request for information and/or release of medical records
Pursuant to I.C. 16-39-1-4

1. _____
Name DOB

_____
Street Address of Patient

_____
City, State, Zip Code

_____
Telephone

2. _____
Provider Releasing Records

_____
Street Address of Provider

_____
City, State, Zip Code

_____
Staff Signature Date Transferred Out

3. The person or organization to whom disclosure is to be made:

_____
Name

_____
Street Address City, State, Zip Code

4. The purpose of the requested release is:

_____

5. The specific information requested is:

_____

_____

_____

6. This request is good for 60 days from the date signed pursuant to I.C. 16-39-1-1 unless I have indicated otherwise on this form.

7. This request may be revoked by the patient at any time by communicating the intent to the provider. Any information released prior to your revocation can not be retrieved.

_____
Date Signed

_____
Patient's Signature OR
Patient's Legal Representative

_____
Printed Signature

_____
Relationship