



### Medical Records Request Form

By signing this form, I authorize Your Corner Pediatrics to **REQUEST** confidential health information about my child, by requesting a copy of my medical records, or a summary or narrative of my child's protected health information from the physician/person/facility/entity listed below.

Patient name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

The information requested is as follows:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Initial next to each selection to also include:

\_\_\_\_\_ Mental Health Information                      \_\_\_\_\_ Genetic Testing Information  
\_\_\_\_\_ HIV/AIDS Information                              \_\_\_\_\_ Substance Abuse Diagnosis/Treatment

My health information covering the period from \_\_\_\_\_ (date) to \_\_\_\_\_ (date)

Request my child's protected health information **FROM** the following physician/person/facility/entity:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Description of Personal Representative

**SEND** records to:  
**Your Corner Pediatrics**  
Address: 819 E 64th Street Indianapolis IN 46220  
Fax: 317-720-2753  
Phone: 317-458-9079  
Email: [info@yourcornerpeds.com](mailto:info@yourcornerpeds.com)