WP
Wayland Pediatrics

Please be advised that I would like to have my child(ren)'s medical records transferred.
I hereby authorize you to release copies of the medical records for:

Name of Child(ren) D.O.B.

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Reason for
Request:____
____

(1) I will pick up the records OR (2) Please send the records to:

____
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Parent's (or child over 18) signature______________________ ____________
Date of request

Parents/Patients:
Please be advised that there is a $15.00 administrative fee per chart for preparing copies of records for transfer. **If you want the records mailed, there is an additional cost of $10.

Date records picked up/mailed:____________________fee paid by: cash check credit card

Signature of person picking up records:______________________________

Printed Name:______________________________