REIS PEDIATRICS
KAILUA PROFESSIONAL CENTER I | 30 AULIKE ST, SUITE 500, KAILUA, HI 96734 | 808.263.8822
WWW.REISPEDIATRICS.COM

Medical Records Request Form

I have requested a summary of the medical records for my children:

Name: _____ DOB: _____

_____ _____

_____ _____

Please select one of the following:
O Send record electronically through passport with no charge.
O Send record electronically via email, fax, or exported to a CD for $50 per patient.
O Paper copy of medical summary for $50 per patient. If I prefer the entire medical record there will be an additional charge of $0.50 per page.

Forwarding Address: _____

_____

Email Address (need one for each child's record): _____

_____

Permanent Cell Number: _____

Reason for Requesting Records: _____

We request that your credit card information be on file with us to process any outstanding balances on your account. Our billing specialist will notify you before any transaction and will mail a receipt to your billing address.

Name on card: _____ Card Number: _____

Expiration Date: _____ Security Code: _____ Card Type: Visa/Mastercard/Discover

Billing address for statements:

Name of person requesting:_____

Signature:_____

Relation to patient:_____

Date:_____

Office Use Only

Outstanding Patient Balance: _____ Outstanding Insurance Balance: _____

Date Payment Collected:_____ CA CC CK

Date Patient Pick Up:_____