Request For Medical Records

7110 Forest Avenue, Suite 105, Richmond, VA 23226
T. 804-377-7100 :: F. 804-377-8511

To: _____
(Please specify your child(ren)'s doctor's office here)

By Fax: _____
(Please enter your doctor's fax number here)

Please accept this written request to transfer the complete medical records for my child(ren) named below.

Each Patient(s) Legal Name	Date of Birth

All records to be sent to:

Partners in Pediatrics, P.C.
7110 Forest Avenue, Suite 105
Richmond, VA 23226

I understand that the physician's office listed above will receive all requested medical records within thirty days from the date signed, in a manner compliant with the HIPPA legislation as specified by Virginia statue. I understand that receipt of a processing fee is not a condition of transferring my records and you may contact me (the parent or guardian) at the address and phone number listed below if any fees are to be assessed.

Signature of Parent or Legal Guardian	**Today's Date**

Street Address of Parent or Legal Guardian	**City**	**State**	**Zip Code**

Print Name	**Relationship to Patient(s)**	**Daytime Phone Number**