AUTHORIZATION TO TRANSFER RECORDS

Date:

To: Dr. Vicki Papadeas, M.D.
PO Box 135
Callicoon, NY 12723

I hereby authorize Dr Papadeas to forward a copy of patient's medical records to:

(Parent/Patient) Name: _____.

Address: _____.

I am requesting:

- ❑ $50 + postage ($6.45) - a printed summary of medical information / EHR (ie. test results, growth charts, and immunizations, etc.)
- ❑ A full printed copy of paper and electronic records, at a cost of $0.75 per page, plus postage. Please note that many charts are greater than 200-300 pages.

Please notes all record copies will be **printed and sent via priority mail to retain confidentiality

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If patient is 18 or older

Patient's Name: _____.

Patient's Signature: _____.

If patient is younger than 18
(All patients older than 18 must sign personally)

Parent/ Guardian's Name: _____.

Patient Name (s):_____

_____

Parent/ Guardian's Signature: _____.

Please mail this form to address above, with check or money order for **$56.45 payable to Vicki Papadeas, MD** for each record summary. If requesting full copies at $0.75/page plus postage return this form and quote will be supplied by return mail (or you may provide your email for faster quote if requested).