Lawrence Pediatrics, p.a.

Request for Medical Records from Lawrence Pediatrics

Lawrence Pediatrics recognizes a patient's right under HIPAA Right of Access and the 21st Century Cures Act to access their personal health information in a cost-effective, secure, and timely manner in the form and format of their choosing.

If Lawrence Pediatrics is unable to provide the requested information in the manner and format requested within 30 days of request, alternative arrangements will be sought to satisfy the request. If any information that is requested cannot be shared or is exempt from the patient's right to access the requester will be notified.

Patients have access to their electronic health information (EHI) at no cost via the patient portal. EHI from the portal can be downloaded and shared at the patients discretion. Alternate forms and formats for PHI/EHI requested by the patient will incur a charge as listed below.

By signing this release, you authorize Lawrence Pediatrics to provide a copy, summary, or narrative of medical records (as indicated by the checkmark(s) below) or otherwise release confidential information. You agree to pay the charges for the form and format you have chosen.

Reason for Request:

_____ Switching Provider _____ Personal Use _____ Lawyer / third party

Form / Format Requested and applicable charge:

____ Paper Copy. $25.00 + 75 cents per page (over 10 pages)- maximum charge up to $150. $25 due at signing.

____ Unencrypted e-mail. Per the Right of Access rules a patient/guardian has the right to receive PHI/EHI via unencrypted e-mail provided they are made aware of the potential security risks to PHI/EHI while in transit. By choosing this form/format you are accepting the risks associated with unencrypted e-mail and will not hold Lawrence Pediatrics responsible for any security breach. E-mail is subject to size restrictions and may not be an option with larger files.

E-mail address for EHI/PHI _____.

Records Requested:

____ Summary of Care (most recent Well Child Check, Sick Visit, Immunization Record, Growth Charts)

____ Complete record (may include previous provider records and specialist notes)

____ Other, please specify: _____

_____ _____ _____

Patient Name | Date of Birth | Date Requested

Release to the following person(s):

Name _____Address _____

_____

☐ I wish to pick up my records in the office. Please call me at _____ when ready.

☐ I wish to have my records mailed to the address above. I agree to pay $5 for postage and handling.

_____ _____

Parent/Guardian Name | Patient (Parent if under 18 years of age) Signature

(updated 03/09/2022)

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