

**PEDIATRIC ASSOCIATES OF RICHMOND, INC. ("PAR")
REQUEST FOR MEDICAL RECORDS**

Patient Name _____ (Date of Birth) _____

Records should be delivered to me at: _____

Information or Records Requested _____

For Dates of Service _____

I understand that I have the right to access my / child/ children's medical records in accordance with the law and the policies of Pediatric Associates of Richmond, Inc. ("PAR"). I understand that PAR may charge me for copies of the medical records, and I have been provided a fee schedule.

I understand that PAR has the right to deny me access to the records in certain circumstances in accordance with the law. If Pediatric Associates of Richmond, Inc. denies me access to requested medical information, I understand it will provide me with the reasons for the denial in writing and describe whether I have the right to have a review of the denial performed by a licensed health care professional.

Please note that information disclosed pursuant to this request is no longer under the control of Pediatric Associates of Richmond, Inc. and may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Printed Name of Parent / Legal Guardian _____

Signature of Parent /Legal guardian _____ Date _____

Relationship to Patient _____