Request To Have Medical Records Sent To

Legacy Pediatrics

I request that ____ send a copy of my children(s) medical records to: Legacy Pediatrics, 1815 South Clinton Avenue Suite 360, Rochester, NY 14618. I understand that this request may take two weeks to complete.

Name____________________________________ Date of Birth __________

Name ____________________________________ Date of Birth __________

Name ____________________________________ Date of Birth __________

Name ____________________________________ Date of Birth __________

I understand all medical records will be sent unless I have checked exceptions:

( ) Drug, alcohol, and related treatment information
( ) Mental health information
( ) Other information as described ____
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Signature _____________________________________ Date___________________

Relationship______________________________________