Use this form if you would like medical records from another location sent to American Fork Pediatrics, Inc.

Dr. Michael D. Whiting, M.D.

American Fork Pediatrics, Inc.
48 North 1100 East, Suite C
American Fork, Utah 84003
(801) 492-4333
Fax: (801) 492-4371

I request that the medical records marked below be released from:

Physician/Hospital Name: _____

Address: _____

Phone/Fax: _____

Authority to Request Records (You must meet one of the following criteria):

- ❑ 1) A parent may request records of his/her children. □ Father □ Mother
- ❑ 2) A patient who is of legal age may request his/her own records.
- ❑ 3) A person holding a power of attorney for a patient (documentation required).
  □ Documentation copied and attached to this request.
- ❑ 4) A person or agency presenting a release of information signed by one of the above specifically authorizing release.
  □ Documentation copied and attached to this request.
- ❑ 5) A court appointed legal guardian may request records (documentation required).
- ❑ 6) These records are being requested for ongoing medical treatment for the below listed patient(s)
- ❑ 7) This request expires one year after the date the request is signed or on _____

Records Requested:

Patient's Full Name	Birth Date	Immunization records	Office Records	Hospital Records	Lab	X-Ray	*Other

Full Name of Patient's Father: _____

Full Name of Patient's Mother: _____

Signature: _____ Date: _____