KIDS CHOICE PEDIATARICS
Request for Electronic Copy of Protected Health Information

Patient's Name: _____ Date of Birth: _____

I request that **Kids Choice Pediatrics** provide me with an electronic copy (available only in PDF format) via email of my protected health information as described below.

Email Address: _____
Please Print Clearly (If we cannot read your email address, we will not send your records.)

Please be advised that our email is not encrypted and may therefore be at risk of being accessible by unauthorized individuals. By checking the box below, you are acknowledging that you have been made aware of these risks and give your permission for this office to email your protected health information to the email address you have provided above.

☐ I acknowledge that I have been notified of the risk of unencrypted email.

Description of Protected Health Information to be disclosed:

☐ Patient's Immunization Record

☐ Patient's Tennessee Department of Health CERTIFICATE OF IMMUNIZATION.

☐ Healthcare information relating to the following treatment, condition, or dates of service:

_____

_____

☐ All healthcare information (Please be aware that there is a fee associated with this request. Please contact our office for more information.)

☐ Other: _____

_____

_____

Signature of Parent/Legal Guardian: _____ Date: _____

Printed Name:_____

Relationship to Patient: _____