

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION
PEDIATRIC

This release expires 90 days from the date of signature or upon written request

Patient's Name: _____
Date of Birth: _____ Patient's Social Security Number: _____
Previous Name Under Which Records May Be Filed: _____
Patient's Current Address: _____
Patient's New Address if Moving: _____
Patient's Current Phone Number: _____ Patient's New Phone Number if Moving _____

I specifically authorize:
Name of Doctor/Facility: _____
Address: _____
To release my child's medical records as described on this form for the following reason _____

I understand that when the information is released, it may be subject to re-disclosure by the recipient and may no longer be protected Personal Health Information (PHI)

Please release my child's Medical Records to:
Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Please initial the appropriate box to indicate which records you wish to be released and be charged for:

- _____ Immunization records only.
- _____ Records generated in this office only (**not including** x-rays, fetal monitor strips, Electrocardiograms, old records, outside lab results) If no box is initialed, this option will be used
- _____ Records generated in this office only (**including** x-rays, fetal monitor strips, electrocardiograms, old records, outside lab results, which may incur an additional charge).
- _____ Other: _____
(specific dates of treatment or specific parts of the record).

PARENTAL / GUARDIAN / LEGAL REPRESENTATIVE AUTHORIZATION:

PLEASE NOTE: If you are a divorced or legally separated parent, or the guardian/legally-appointed representative of the patient. With your signature below, under the terms of the court order governing your divorce or legal separation, or the guardianship/appointment as legal representative of the patient, you have the right to inspect and obtain the release of medical records, and the right to make medical decisions on behalf of the patient.

Parent Signature _____ Date _____
(patients 18 years and older must sign for themselves)

OR

Signature of Guardian/Legal Representative _____ Date _____
Relationship to Patient _____

PATIENT AUTHORIZATION: Records identified below cannot be released without the patient's written consent.

I understand that this separate, expressed consent is required to release sensitive healthcare information in my record, and I specifically request that you release any information in my medical record pertaining to discussion, testing, diagnosis, or treatment regarding sexual activity, reproduction, birth control, sexual- or reproductive-related diseases, and addiction to or use of drugs.

Patient Signature _____ Date _____

