PEDIATRIC SERVICES

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

Patient Name _____ Date of Birth_____

WHO HAS INFORMATION YOU WOULD LIKE RELEASED?

Name _____ Address_____

City_____ State _____ Zip_____

Phone _____ Fax _____

TO WHOM SHOULD THE INFORMATION BE SENT?

Name _____ Address_____

City_____ State _____ Zip_____

Phone _____ Fax _____

This information is being released at the request of the individual for the following purpose:

☐ Continuation of Care ☐ Insurance Claim ☐ Litigation ☐ Other

The following information is routinely copied from the previous two years – if other information is needed, please specify. Dates from _____ to _____

__ Discharge Summaries __ Operative Reports __Consultations __ Education Records
__ Emergency Dept. Visits __ Laboratory Reports __Clinic Visits __ Mental Health Records
__ History and Physicals __ Immunizations __X-rays __ Testing Records
__ Hospital Reports __ Other _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, child abuse, and treatment for alcohol and drug abuse.
I understand that I have a right to stop this authorization at any time. I understand that if I stop this authorization, I must do so in writing. I understand that stopping this authorization will not apply to information that has already been released or disclosed.

Unless otherwise revoked, this authorization will expire in one year.

I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal privacy rules.

_____ _____ _____
Signature of the Parent/Guardian/Patient Date Signed Relationship to Patient