*******PLEASE MAIL OR E-MAIL THE RECORDS IF MORE THAN 20 PAGES*******

Medical Release

I, _____ (**Parent/Legal Guardian**), hereby authorize _____ to:

_____ Release Copies of the medical records of my child
_____ (**Patient name, DOB, and SSN**) to:

_____ Obtain copies of the medical records of my child

_____ (**Patient name, DOB, and SSN**) from:

_____
Name of Facility and/or Physician Phone Number/ Fax Number

_____
Address

_____
City State Zip

THE FOLLOWING:

- ☐ Hospital records including Hx & Phys and Discharge Summaries from the dates: _____ to _____
- ☐ Emergency Room Notes from the period: _____ to _____
- ☐ Diagnostic Tests and Labs
- ☐ Immunization Records (Please fax Immunization Records, all other requested records may be sent by mail)
- ☐ Office Notes from this period: _____ to _____
- ☐ Complete Medical Record

PURPOSE OF DISCLOSURE:

- ☐ Referral to Specialist
- ☐ Change of Physician
- ☐ Continuing Care
- ☐ Insurance
- ☐ Workers Comp
- ☐ Personal
- ☐ Legal Investigation
- ☐ Disability Determination/SSI
- ☐ Other, please specify: _____

INFORMATION TO BE EXCLUDED, NOT RELEASED:

- ☐ Mental Health Records
- ☐ Sexual Assault/ Victimization Records
- ☐ HIV Testing
- ☐ Drug Alcohol Treatment
- ☐ Other, please specify: _____

I hereby authorize disclosure of the health information for the above name patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____ _____
SIGNATURE OF PARENT/LEGAL GUARDIAN RELATION TO PATIENT DATE