PEDIATRICS AND FAMILY CARE

Medical Record Release Authorization

I, _____ (**Parent/Legal Guardian**), hereby authorize **Pediatrics and Family Care to r**elease copies of the medical records of:

_____

(**Patient name, DOB, and SSN**)

TO:	FROM:
Address:	Address:
City, St, Zip Code	City, St, Zip Code
Office:	Office:
Fax:	Fax:

*THERE IS A NOMINAL COPYING FEE OF $1.00 PER PAGE FOR PERSONAL REQUEST. OTHERWISE, REQUEST WILL BE SENT TO ANOTHER DOCTOR'S OFFICE.

THE FOLLOWING:

- Hospital records including from the dates: _____ to _____
- Diagnostic Tests and Labs
- Immunization Records
- Office Notes from this period: _____ to _____

PURPOSE OF DISCLOSURE:

- Referral to Specialist
- Change of Physician
- Continuing Care
- Insurance
- Personal

INFORMATION TO BE EXCLUDED, NOT RELEASED:

- Mental Health Records
- Sexual Assault/ Victimization Records
- HIV Testing
- Drug Alcohol Treatment

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