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Authorization to Release Medical Information

Patient (child's) name:_____ Patient (child's) date of birth: _____

Person requesting authorization: _____

Your relationship to the patient (parent or legal guardian): _____

I, _____, hereby consent to the release and disclose personal health information of above mentioned patient to:

Physician (facility) name:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

For the following purpose:

□ Referral □ Physician Change/second opinion

□ Primary Care Physician □ Other reason:_____

Which medical information would you like to be released:

□ All Records □ Information for a specific date of service _____

□ Investigations (labs, procedures or radiology tests etc)

Other:_____

I understand that the information outlined in this release will be disclosed within 2 weeks after we receive this release authorization. I understand that I am free to revoke this release authorization at any time by notifying the practice in writing. I also understand that the information disclosed under this release is subject to re-disclosure and no longer protected by the Privacy Regulations (45 C.F.R. 164).

Your name:_____

Signature:_____ Date:_____