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Authorization to Release Medical Information

Patient (child's) name: ____

Patient (child's) date of birth: ____

The **person requesting this authorization**: ____

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

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

Physicians (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, 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: ____________________