

**Pediatric Clinic, P.A.**

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**Authorization for Release of Records**

**Patient Name** \_\_\_\_\_ **DOB** \_\_\_\_\_

**Address** \_\_\_\_\_ **Phone** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

Please choose Option 1 or Option 2 and complete the appropriate box.

**Option 1:** Send from another physician to The Pediatric Clinic, P.A.

<b>Sending Physician, please release my child's health information to the Pediatric Clinic, P.A.</b>		
Sending Physician Name: _____		
Street: _____		
City: _____	State _____	Zip _____
Phone: _____	Fax _____	

**Option 2:** Send from The Pediatric Clinic, P.A. to another physician.

<b>Pediatric Clinic, please release my child's protected health information to the following doctor.</b>		
Receiving Physician Name: _____		
Street: _____		
City: _____	State _____	Zip _____
Phone: _____	Fax _____	

**Please release the following:**

- |  |  |
|--|--|
| <input type="checkbox"/> All Records (or check the following that apply) | <input type="checkbox"/> Diagnostic Reports (Lab/Xray/EKG) |
| <input type="checkbox"/> Progress Notes                                  | <input type="checkbox"/> Hospital Reports                  |
| <input type="checkbox"/> History/Physical Exam                           | <input type="checkbox"/> Other (Specify) _____             |
| <input type="checkbox"/> Immunization Record                             |  |

**The reasons or purposes for this release of information are as follows:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. I also consent to the release of information related to behavioral or mental health services and treatment for alcohol and drug abuse.

Yes, I consent to the release of this information.  No, I do not consent to the release of this information.

**I understand that I may revoke this authorization at any time in writing by sending written notification to the practice, otherwise this authorization shall expire on the 365<sup>th</sup> day after it is signed.**

\_\_\_\_\_  
**Patient Signature [or parent, guardian or legal representative]**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Relationship to Patient [If parent, guardian or legal representative]**

\_\_\_\_\_  
**Witness**