



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 provider to Pediatric Clinic Mount Pleasant

Please release my child's health information to the Pediatric Clinic Mount Pleasant			
Sending Provider Name: _____			
Street: _____			
City: _____	State _____	Zip _____	
Phone: _____	Fax _____		

Option 2: Send from Pediatric Clinic Mount Pleasant to another provider or individual

Pediatric Clinic Mount Pleasant, release my child's health information to the following:			
Provider or Individual 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 365th day after it is signed.

Patient Signature [or parent, guardian or legal representative]

Date

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

Witness