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MEDICAL RECORDS AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT FULL NAME ____DOB____________
____DOB____________
____DOB____________
____DOB____________
____DOB____________
ADDRESS____

AUTHORIZES RELEASE OF RECORDS

	TO: (where the records are going)	FROM: (who has the records now)
HEALTH CARE FACILITY	______________________	_______________________
STREET ADDRESS	______________________	_______________________
CITY, STATE, ZIP	______________________	_______________________

INFORMATION TO BE RELEASED:

___ENTIRE MEDICAL RECORD
___IMMUNIZATION RECORDS
___LABORATORY REPORTS
___RADIOLOGY REPORTS
___HOSPITALIZATION REPORTS
___OTHER ______________________________

PURPOSE OR NEED FOR DISCLOSURE:

___MOVING/CONTINUATION OF CARE
___INSURANCE CHANGE
___PERSONAL COPY
___LEGAL
___SCHOOL
___OTHER ______________________________

I UNDERSTAND THAT IS AUTHORIZATION SHALL BE VALID FOR 90 DAYS FROM THE DATE OF SIGNATURE.

I AUTHORIZE RELEASE OF MY CHILD'S MEDICAL INFORMATION IN ACCORDANCE WITH THE SPECIFICATIONS LISTED ABOVE. I UNDERSTAND WRITTEN NOTICE IS NECESSARY TO CANCEL THIS REQUEST.

I ALSO UNDERSTAND THAT THE HEALTH INFORMATION THAT MAY BE DISCLOSED INCLUDES ANY INFORMATION CONCERNING HIV TESTING AND THE TREATMENT OF AIDS, AIDS RELATED CONDITIONS, DRUG OR ALCOHOL ABUSE, DRUG RELATED CONDITIONS, AND/OR PSYCHIATRIC PSYCHOLOGICAL CONDITIONS.

SIGNATURE OF PARENT/GUARDIAN:_______________________________________DATE_________
LEGAL AUTHORITY IS: ____PARENT____LEGAL GUARDIAN____OTHER(SPECIFY)________________

___PLEASE FAX AN IMMUNIZATION RECORD IMMEDIATELY. PATIENT IS IN THE OFFICE AT THIS TIME.