Authorization for Release of Medical Records

Patient Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

I do hereby authorize:
Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

to release the following medical information on the above patient:

___ All PHI in medical record
___ Laboratory
___ Imaging/Radiology
___ Other:_____
___Growth chart & Shot record
___ Psychological Evaluation
___ Psychotherapy notes/ADHD

This information is to be released to:
Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

Reason for request: ☐ Change of Insurance ☐ Moving out of area ☐ Specialist
☐ New Physician, reason:_____ ☐ Other _____

I understand that any drug abuse, alcohol abuse, sexually transmitted disease, HIV/AIDS, psychotherapy or mental health related information, if present, ***will*** be disclosed with this authorization unless excluded here: _____

I understand that I may revoke this authorization, in writing, at any time, except to the extent that action has already been taken in reliance on this authorization. This authorization will remain in effect for 90 days in order to effect the purpose for which it is given unless earlier revoked in writing.

_____ _____
Parent/Guardian Name **Parent/Guardian Signature**

_____ _____
Relationship to Patient **Date**

_____ _____
Witness **Date**