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# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

**I hereby authorize the release of information from the medical record of:**

Patient Name: _____ Date of Birth: _____
Patient Name: _____ Date of Birth: _____
Patient Name: _____ Date of Birth: _____
Patient Name: _____ Date of Birth: _____

**Please Release Information To:**

Name: _____
Address: _____
City/State/Zip: _____
Telephone: _____
Fax: _____

**Information to be Released:**

□ Immunization Record/Growth Chart/Last Well Visit □ Labs/X-Rays

**Reason for Release of Information:**

□ Change of Physician □ Personal Use □ Attorney / Legal
□ Change of Insurance Please specify your new carrier: _____

**Informed Consent for Release of Confidential Information**

- I understand that once I have requested the transfer of records our relationship with ABC Pediatrics will be terminated. Any questions, concerns or need for care will be directed to your new physician.
- I understand that I may revoke this consent in writing at any time.
- I understand that this consent will expire 90 days after the date of my signature unless otherwise specified.
- I understand that there is a fee for copy services rendered.
- I understand that this information may include HIV/AIDS, mental health and chemical dependency diagnosis, treatment, and test results.
- I understand that the information released is for the specific purpose stated above.
- I understand that my medical records may contain reports only a physician can interpret.
- I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.
- I will not hold ABC Pediatrics liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of Patient or Legal Representative Date

_____
Relationship to Patient

Request Received: _____ Payment Received: _____ Records Sent: _____