MEDICAL RECORD RELEASE AUTHORIZATION

Please print legibly in black or blue ink. Each patient requires separate form.

Patient Name: ______________________Date of Birth: ________________Phone: ______________

Address: ____

City State Zip

____ **I hereby authorize the following healthcare provider/institution to release photocopies of my (child's) entire medical record to Pediatric and Adolescent Care, L.L.P.**

Institution/physician authorized to release information: ______________________________

Address: ____

Phone: ___________________________ Fax: ___________________________

____ **I hereby authorize Pediatric & Adolescent Care, L.L.P. to release photocopies of my (child's) entire medical record to the healthcare provider or institution listed below.**

Institution/physician authorized to release information: ______________________________

Address: ____

Phone: ___________________________ Fax: ___________________________

____ **I hereby authorize Pediatric & Adolescent Care, to release photocopies of my (child's) medical record to me for my own keeping.**

Description of information to be released: ____

____

Reason for release:____

(MUST BE COMPLETED)

The information authorized for release may include records which may indicate the presence of a communicable and non-communicable disease. This may also include information about psychiatric conditions and substance abuse.

Once received, the medical records will be protected in accordance with PAC's health information privacy statement, which I have received a copy of, as well as applicable state and federal guidelines including the Health Information Portability and Privacy Act (HIPAA). I understand that this release of information is for the purpose of continuing medical care and/ or consultation. I may revoke this authorization at any time and it will automatically expire one year from the date of my signature.

I understand that this release of information is for the purpose of continuing medical care and/ or consultation. I may revoke this authorization at any time and it will automatically expire one year from the date of my signature.

Signature of parent or authorized guardian: ______________________________ **Date:** ______________

Relationship to patient: ____

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