All Better Pediatrics

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Authorization to Release Medical Records/Information

Physician to provide records: _____

Former Physician's Address: _____

Former Physician's Phone: _____

Patient's Name: _____

Date of Birth: _____

Social Security #: _____

Release these records: (Circle those that apply)

1. Only records generated by this facility (not including records received from other sources)
2. Only some portion of records maintained at facility (dates of treatment, etc.)
3. All medical records at this facility

Initial: _____

IF YOU DO NOT WANT CERTAIN PORTIONS OF YOUR MEDICAL RECORDS RELEASED, PLEASE READ THIS SECTION CAREFULLY AND INITIAL THE BOXES FOR INFORMATION YOU DO NOT WANT RELEASED. OTHERWISE, YOU RECORDS WILL BE RELEASED AS SPECIFIED ABOVE.

I authorize the health care provider to release the information specified to the organization, agency, or individual named on this request with the EXCEPTION of:

Initial:
_____ Substance abuse, if any
_____ Psychological or psychiatric conditions, if any

Initial:
_____ AIDS/HIV, if any

Other (Please specify) _____

Expiration or revocation of authorization – I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below. Use of copies – A copy of this authorization may be utilized with the same effectiveness as an original.

Patient name (print):
_____

_____
Patient's signature

Date: _____

Person authorized to sign for patient:
_____
Print or type name

_____
Signature

_____
Relationship to patient

Date: _____