Authorization for Release of Medical Records

Patient Name: _____ **Gender**: Male / Female
Date of Birth: _____ **Account #**: _____

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
___ Growth chart & Shot record
___ Laboratory
___ Imaging/Radiology
___ Psychological Evaluation
___ Psychotherapy notes
___ Other: _____

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 _____

This medical record may contain information about drug abuse, alcohol abuse, sexually transmitted disease, HIV/AIDS or mental health treatment. Separate consent must be given before this information may be released.

I understand that I may revoke this consent at any time, except where information has already been released.

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

_____ _____
Relationship to Patient **Date**

_____ _____
Witness **Date**