MEDICAL RECORD RELEASE

Patient Authorization for Use and Disclosure of Protected Health Information

Date of Request:_____ To: _____ (Physician at Kidsville Pediatrics)

Authorization Valid Until- Date: _____ (not to exceed 1 year)

Patient Name: _____ Date of Birth: _____

_____ Date of Birth: _____

_____ Date of Birth: _____

_____ Date of Birth: _____

Requested By: _____Relationship to Patient: _____

By signing this I authorize KIDSVILLE PEDIATRICS to release the Medical Records (Protected Health Information on the above named children). This Protected Health Information

is to the sent to:

Complete Name and Address of Physician or Clinic

_____

_____

_____

Patient/ Parent/ Legal Guardian Signature: _____

(Patient if over 18 years old)

Check Below:

Complete Chart (There is a charge for this) Check medical information you want sent:

_____ Records forwarded by previous physicians _____ X-Ray reports

_____ Medical records while under our care _____ Consultations

_____ Hospital administration _____ Laboratory results

_____ ALL OF THE ABOVE

OR

_____ Medication list, immunization record, growth chart and last well visit (there is a charge for this)

_____ Other, please specify what is needed:

_____

Primary Physician Signature: _____

Release Completed By: _____ Date Sent: _____