

Authorization For Release of Medical Information

Patient's Full Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Cell Phone: _____

I hereby authorize and request The ChildHealth Center, P.A. to release information to:

Name of Provider or Facility

Address

City, State, Zip Code

Phone#/Fax# (include area code)/Email

Medical Information to be released: All records concerning previous history, evaluation and treatment (including immunization record)
 Other _____

Purpose for this request: (Check one) Personal Copy Legal Insurance Continuation of Care
 Dissatisfaction (Reason) _____
 Other (specify) _____

FORMAT AND DELIVERY OF INFORMATION

Preferred Methods of Delivery: Encrypted Email or CD or Fax (providers only)

Mail Delivery: CD or Paper (fees may apply)

In-Person Pick up Name: _____ CD or Paper (fees may apply)

I do hereby consent and authorize you to release copies of my medical records. PLEASE NOTE: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information, and any information relating to HIV testing, AIDS, and any AIDS related syndromes. It also includes any information concerning cancer, cancer testing and cancer results. I agree that a copy of this release or a fax of this release shall be as valid as the original release. Please send copies of all requested information as soon as possible to the address listed above.

I understand that I may revoke this Authorization in writing at any time, except to the extent that action has already been taken in response to the Authorization. I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy law. I understand that I may refuse to sign this Authorization. A reasonable cost-based fee may be charged for copies of records being requested. I also understand that the release of information can take anywhere from 7-10 business days.

Signature of Patient or Legal Guardian

Date*

Print Name of Patient or Legal Guardian

Relationship to the patient

*Release request expires 90 days from signature date.