the ChildHealth Center, P.A.

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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 obtain information from:

____
Name of Provider or Facility

____
Address

____
City, State, Zip Code

____
Phone#/Fax# (include area code)

Medical Information to be released: ___All records concerning previous history, evaluation and treatment (including immunization record)
___Hospital records
___Other______________________________

Purpose for this request: (Check one)___Personal Copy ___Over age 21 ___Insurance Change ___Relocation ___Referral to Specialist
___Dissatisfaction (Reason)______________________________
___Other______________________________

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.

______________________________ ______________________________
Signature of Patient or Legal Guardian Date*

______________________________ ______________________________
Print Name of Patient or Legal Guardian Relationship to the patient

*Release requests expire 90 days from signature date.

FOR INTERNAL PURPOSES ONLY: Name & Title of Person Releasing Records______________________________
Method of Transfer: ___Mailed on (date) ______________
___Faxed to (number) ______________________ on (date) ______________
___Picked up by (name) ______________________ on (date) ______________
___Release faxed on (date) ______________