# PEDIATRIC SERVICES

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

Patient Name_____Date of Birth_____

**WHO HAS INFORMATION YOU WOULD LIKE RELEASED?**

Name_____

Address _____

City_____State_____Zip _____

**TO WHOM SHOULD THE INFORMATION BE SENT?**

Name _____Fax _____

Address _____

City_____State_____Zip _____

This information is being released at the request of the individual for the following purpose:
____Continuation of Care _____Litigation/Legal _____ Other _____Transfer of Care

The following information is routinely copied from the previous two years – if other information is needed, specify below.

___Discharge Summaries ___Operative Reports___Consultations___Education Records
___Emergency Dept. Visits ___Laboratory Reports__Clinic Visits ___Mental Health Records
___History and Physicals ___Immunizations ___X-rays Testing Records
___Hospital Reports ___Other _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, child abuse, and treatment for alcohol and drug abuse.
I understand that I have a right to stop this authorization at any time. I understand that if I stop this authorization, I must do so in writing. I understand that stopping this authorization will not apply to information that has already been released or disclosed.

**Unless otherwise revoked, this authorization will expire in one year.**

I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal privacy rules.

_____ _____ _____
Signature of the Parent/Guardian/Patient Date Signed Relationship to Patient