

## Authorization to Release Medical Information

**Patient Information:**

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

I hereby authorize Great Destinations Pediatrics, PC to **SEND** photocopies of medical records concerning the above named patient (s) **TO:**

<p><b>Practice/ Company or Person(s) authorized to receive records:</b> <b>Name:</b> _____ <b>Address:</b> _____ _____ _____ <b>Phone:</b> _____ <b>Fax:</b> _____ <b>For the purpose of:</b> _____</p>
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**(Check all that apply)**

Records to be included:

\_\_\_\_\_ All Medical Records      \_\_\_\_\_ Immunization Record

\_\_\_\_\_ Copies of Medical Records for the Period:

\_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo Day Year    Mo Day Year

\_\_\_\_\_ Copies of Information described below for the Period:

\_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo Day Year    Mo Day Year

\_\_\_\_\_ Consult Reports      \_\_\_\_\_ Lab, X-Ray

\_\_\_\_\_ Other (Please Specify) \_\_\_\_\_

\_\_\_\_\_ The following information should **not** be released (Please Specify) \_\_\_\_\_

<p>We want to thank you for entrusting our practice with providing medical for your child/children. We appropriate feedback and would like to know your reason for requesting records.</p> <p>_____ Moving out of Geographical Area      _____ Changing of Physician _____ Insurance Change      _____ Parent/Legal Guardian's Copy _____ Legal      _____ Customer Service</p>
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In accordance with federal regulations, I hereby consent to the release of records pertaining to treatment/diagnosis of the following should records contain this information: Condition relating to drug and/or alcohol abuse, condition related to psychiatric/psychological treatment, AIDS/HIV, and communicable diseases.

This request will remain in effect for 1 year from the date of this request.

I understand that I may revoke this authorization at any time in writing except to the extent that action based on this authorization has already been taken. **PLEASE ALLOW 14 BUSINESS DAYS FOR ALL MEDICAL RECORD REQUESTS**

\_\_\_\_\_  
Signature, Parent/Legal Guardian      Relationship to Patient      Date

Records Prepared by \_\_\_\_\_ Date \_\_\_\_\_