Pediatric & Adolescent Care

MEDICAL RECORD RELEASE AUTHORIZATION

Please print legibly in black or blue ink. Each patient requires separate form.

Patient Name: _____Date of Birth: _____Phone: _____

Address: _____

City State Zip

____ **I hereby authorize the following healthcare provider/institution to release photocopies of my (child's) entire medical record to Pediatric and Adolescent Care, L.L.P.**

Institution/physician authorized to release information: _____

Address: _____

Phone: _____ Fax: _____

____ **I hereby authorize Pediatric & Adolescent Care, L.L.P. to release photocopies of my (child's) entire medical record to the healthcare provider or institution listed below.**

Institution/physician authorized to release information: _____

Address: _____

Phone: _____ Fax: _____

____ **I hereby authorize Pediatric & Adolescent Care, to release photocopies of my (child's) medical record to me for my own keeping.**

Description of information to be released: _____

_____

Reason for release: _____

(MUST BE COMPLETED)

The information authorized for release may include records which may indicate the presence of a communicable and non-communicable disease. This may also include information about psychiatric conditions and substance abuse.

Once received, the medical records will be protected in accordance with PAC's health information privacy statement, which I have received a copy of, as well as applicable state and federal guidelines including the Health Information Portability and Privacy Act (HIPAA). I understand that this release of information is for the purpose of continuing medical care and/ or consultation. I may revoke this authorization at any time and it will automatically expire one year from the date of my signature.

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Signature of parent or authorized guardian: _____ Date: _____

Relationship to patient: _____

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