



# PEDIATRICS, P.C.

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## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

*The below is to ensure your right to privacy. Please complete in its entirety.*

**EFFECTIVE MAY 1, 2011, THERE WILL BE A \$25 CHARGE PER CHILD TO  
TRANSFER RECORDS**

I authorize \_\_\_\_\_ to release the following medical  
(Name of physician/facility)  
information regarding \_\_\_\_\_  
(Patient's name on record)  
Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Please initial appropriate line)

\_\_\_\_\_ Any and all of patient's medical records (as of the date of this release) or  
\_\_\_\_\_ Send specific records listed below:  
\_\_\_\_\_  
\_\_\_\_\_

This release also specifically allows the release of the following information (this information will be released unless the appropriate line is initialed):

\_\_\_\_\_ Any record of treatment for drug and/or alcohol dependency or abuse;  
\_\_\_\_\_ Any record of mental health treatment;  
\_\_\_\_\_ Any record of testing, care, treatment, reporting or research pertaining to infection with HIV or related diseases.

This information is being released for the following purpose(s) only: \_\_\_\_\_

\_\_\_\_\_ and may not be used for any other purpose or released to any other person(s) without my written consent.

This release is effective for one (1) year from the date of execution; however, I may revoke it at any time by providing notice in writing to the above named party.

\_\_\_\_\_  
Patient/Legal Guardian Date Phone Number

\_\_\_\_\_  
Witness Date