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AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION

Patient's Name:_____ Date of Birth:_____

Patient's address:_____ Phone: _____

I hereby authorize the request of medical records FROM:

Physician/Clinic/Hospital: _____

Address: _____

Phone:_____ Fax: _____

Reason for request: _____

To be released TO:

Physician/Clinic/Hospital: _____

Address: _____

Phone:_____ Fax: _____

Please release the following information:

- ☐ Immunization records
- ☐ Progress notes
- ☐ Medical summary (if any)
- ☐ Growth charts
- ☐ Cardiac studies
- ☐ Other: _____
- ☐ Imaging/radiology reports/Lab results
- ☐ Consultation repots
- ☐ Psychiatric/Psychological reports
- ☐ Speech/Language/Audiological Reports
- ☐ Permanent School Reports
- ☐ **Complete Records**

I, the undersigned, have read the above and authorize the disclosure of such protected health information as described herein. I understand that treatment is not conditioned upon execution of this authorization. I understand that if the person of entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. I understand that fees may be charged for preparing and sending copies of records as permitted by law. I understand that I may revoke this authorization at any time by providing a written notice to Riverview Pediatrics. (Note: Revocation is not effective for disclosures that have already been made.) I also understand that Riverview Pediatrics will send one free copy of medical records to the physician to which I am transferring care and that any other requests for medical records will result in a $25.00 charge.

_____

Signature of parent/guardian Date

_____

Name and Relationship to patient

_____

Witness Date *(Revised 2/2017)*

we care about the little things...