Medical Records Release Form

Authorization of Health or Billing Information

Patient Name:	**Patient Address:**
Date of Birth:	**Phone Number:**
I give permission to:	**To release my information to:**
(Name of Person/Facility)	**(Name of Person/Facility)**
(Address)	**(Address)**
(City/State/Zip)	**(City/State/Zip)**
(Phone) (Fax)	**(Phone) (Fax)**

Please Check Information to be Released:

□ **Registration Information** □ **Specific Treatment Dates:** □ **Entire Medical Record**
□ **Insurance Information** _____ □ **Immunization Record**
□ **Medication Records** _____ □ **Other** _____
□ **Consultation Notes** □ **Growth Chart** □ **Labs** □ **Xrays** □ **Psychiatric Notes**

Describe Reason for Release:

□ **Insurance** □ **Legal** □ **Changing Physicians (if choosing this option please let us know why)**
□ **Other** _____

Records to be Released by:

□ **Mail (will be mailed to whomever information is being released to)**
□ **Fax (cannot fax entire medical record)**
□ **Pick-Up in person**
□ **Other (describe)** _____

****Fee for copying/handling entire medical record is $20.00. You will be pre-billed for the records. As soon as the invoice is paid your records will be mailed on CD/R unless requested on paper. Please allow 5-10 business days for records to be received.**

I authorize the disclosure of medical information for the above named patient(s). I understand that this authorization is voluntary and may be revoked in writing at any time. I understand that this authorization may be revoked in writing, unless the medical records have already been disclosed. I understand that this authorization includes consent for information that may include susbstance abuse, mental health, and HIV/AIDS. I understand that this authorization is valid for 12 months from the date signed.

_____

Patient/Parent Signature **Date**

_____

Print Name **Relationship to Patient**