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** FAXED OR MAILED RECORDS RELEASE MUST BE ACCOMPANIED BY PARENT OR GUARDIAN PICTURED ID & WITNESS FULL SIGNATURE, ADDRESS, PHONE NUMBER **

Consent to Release Information

☐ Fax ☐ Mail ☐ Pick Up

I hereby authorize:

____
Name
____
Address
____

____
Phone   Fax

To release to:

____
Name
____
Address
____

____
Phone   Fax

This is to authorize you to release the requested information on the below named individual(s):
(One patient. If you need more space please enter the information on the back.)

____ ____________________________
Patient Name   Date of Birth

Information Requested:
☐ Standard Records; (last 3 yrs. office visits, physicals, Growth chart, vaccines, problem list, labs, hospital notes)
☐ Limited Records dates/events :(___________________________)
☐ Complete Records (copying fee charged)
☐ Psychiatric Records
☐ Limited Records can be copied to a flash drive (Allergies, Medications, Results, Vitals, Past Surgical, Social, Family, Past Medical histories, and Active Problem list)

Reason(s):
☐ Consult
☐ Moving
☐ Changing Doctors
☐ Insurance
☐ Other: ______________________________
____
____

Please allow 5-7 business days for record request completion

<u>First copies no charge; any extra copies will include a copying Fee</u>

I request and authorize the above named provider/s to release this information. I understand the records may include information regarding the following conditions: drug or alcohol abuse, psychological or psychiatric conditions, developmental disabilities, HIV, AIDS, sexually transmitted diseases, pregnancy or other sensitive information. I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment, my eligibility for benefits, etc. will not depend in any way on whether I sign this authorization or not. I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. This authorization will expire one year from the date below.

__________________________ __________________________ __________________________
Print Name   Relationship to Patient   Signature

__________________________ __________________________
Date   Phone Number

__________________________ __________________________
Witness Signature   Date

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to address or name of office.

____ __________________________
Signature   Date