MEDICAL RECORDS RELEASE FORM

PEDIATRIC CARE GROUP, P.A.

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FAXD
BY:_____
ON: _____/_____/_____

Patient Name: _____

I, _____ Hereby Authorize Pediatric Care Group, P.A.
To □ Release To □ Obtain From □ Self Pay
Name: _____

Address: _____

City: _____

Phone: (_____)_____-_____ Fax: (_____)_____-_____

** PLEASE RELEASE MY MEDICAL RECORDS**
Initial by the item you want to have released

State Period of Time: From: _____/_____/_____ To: _____/_____/_____

____ 1. All Medical Records (Includes #2-8)
____2. Immunization Records
____3. Consultations
____4. Surgical Reports
____ 5. Laboratory Results
____ 6. X-Ray Reports
____7, ER/Urgent Care Records ALL
____ 8. Newborn/Birth Records (Include Screen/Test Results)

Medically Sensitive:
____ HIV/AIDS information
____ Mental Health Information
____ Substance Abuse Information
____ Sexually Transmitted Disease
____ Pregnancy Information (If patient is under 18 years old)

I understand that this consent is revocable by me, in writing, at any time except when action has been taken in reliance upon it. I also understand that this consent will expire ninety (90) days after date of signature or automatically when the records requested on this form have been sent.

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by law. Any further re-disclosure is strictly prohibited.

PATIENT Name: _____Date of birth:____/____/_____

Parent/Guardian: _____ Date: ____/____/_____
(PRINT)

Parent Guardian: _____ Witness: _____
(SIGNATURE)

Last updated 12/28/2016