

MEDICAL RECORDS RELEASE FORM

PEDIATRIC CARE GROUP, P.A.

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FAXED
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: ____/____/____

- | | |
|---|--|
| <input type="checkbox"/> 1. All Medical Records (Includes #2-8) | <input type="checkbox"/> 5. Laboratory Results |
| <input type="checkbox"/> 2. Immunization Records | <input type="checkbox"/> 6. X-Ray Reports |
| <input type="checkbox"/> 3. Consultations | <input type="checkbox"/> 7. ER/Urgent Care Records ALL |
| <input type="checkbox"/> 4. Surgical Reports | <input type="checkbox"/> 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 recognize that the health information disclosed may contain information that is privileged and protected by law & I specifically consent to the disclosure of such information. I understand that I have the right to inspect or copy the information to be used/disclosed as permitted by federal law. All records obtained will be used solely for professional purposes, and will remain confidential. I understand that this consent is revocable by me, in writing, at any time except when action has been taken in reliance upon it. If I refuse to sign this authorization, my treatment, payment health plan enrollment, or eligibility for benefits will not be affected. **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)