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Authorization for Release of Medical Records

I understand that my child's medical records are confidential and cannot be disclosed without my written authorization, except otherwise provided by law.

I hereby authorize the release of the following information from the records of:

Patient Name _____
Birth Date

The information below may be released **to** or **from** (circle one):

Name:			
Address:			
Phone:		Fax:	

Information to be released: (Check all that apply)

_____ Immunization Record _____ Complete Medical Record
_____ Test and/or Results _____ Other

Purpose of disclosure: (Check all that apply)

_____ Legal Purposes _____ Personal File _____ Specialist
_____ Transfer to another Physician _____ School/Day Care Requirement

I [] DO [] DO NOT want to include information relating to sexually transmitted disease(s), acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol or drug abuse.

Copying Fees for Medical Records:

I understand there is a fee for all record release with a charge of \$25.00 for the first 20 pages, and \$0.50 per page thereafter. There will be an additional \$15.00 fee for the execution of an affidavit. **There will be an exception to the fee if "transferring to another physician" or "Specialist"**. Please be advised that the facility you are requesting records from have up to 15 days by law to transfer your records. If records are needed before the 15 days, you may be charged accordingly.

This authorization is valid for one year from the date of signature.

Parent or Guardian Name (Printed) _____
Phone Number

Signature of Parent or Guardian Name _____
Date

if this form is not filled out correctly no records will be transferred or received