Pediatric Partners
with you, for your child... for years to come.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL PATIENT INFORMATION

Patient Name _____

DOB: _____ Telephone Number: _____

Purpose of Release: _____

I HERBY AUTHORIZE PEDIATRIC PARTNERS TO RELEASE MEDICAL INFORMATION TO:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

****Full Medical Record - No charge if records are released to another physician, $1.00 per page for the first 25 pages and $0.25 per page thereafter if released to the parent. If you prefer medical records on a CD disk, the cost is $30.00. Medical records can take up to 7-10 business days to be completed****

HOW YOU WOULD LIKE YOUR MEDICAL RECORDS PREPARED:

☐ I'm requesting medical records on paper

☐ I'm requesting medical records on a CD Disc-$30.00 fee

I AM REQUESTING MEDICAL RECORDS FOR THE FOLLOWING:

☐ Immunization Record

☐ Physical Exams and Growth Charts

☐ Specific Items Requested:_____

Any information including diagnosis and records of any treatment or examination rendered to me including any Federal and State protected information under appropriate statute, Mental Health, Psychotherapy, Substance Abuse, Human Immunodeficiency Virus (AIDS) tests results and treatment. I understand that this authorization will remain in effect for six (6) months or until I revoke it in writing to an authorized employee of Pediatric Partners. I have read Pediatric Partners' Notice of Privacy. I hereby release Pediatric Partners and its employees from any and all liability that may arise from the release of information as I have directed.

_____ _____

Signature of Patient Date

_____ _____ _____

Signature of Empowered Representative Relationship to Patient Date

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