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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize _____

to release to _____

The following information from the medical records of:

Name _____ **Date of Birth** _____

Please indicate date range for (All dates _____) or (From this date _____ to this date _____)

Mother's Name (for Newborn Records): _____ Date of Birth _____

PLEASE SEND US ONLY:

- Immunization information, Problem List and Growth Charts
- Copy of complete medical records
- Lab & X-Ray reports
- Birth Records and Infant Screen (PKU)

The Patient information is needed for:

- Transfer of Care
- Continuity of Care
- Patient Use
- Other: _____

This release, and all authority to disclose information pertaining to my child/children, shall expire on _____ or one year from the date of the signature below, unless earlier revoked by me in writing.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), or alcohol and drug abuse. I authorize the release or disclosure of this type of information.

I understand the following: See CFR §164.508(c)(2) (i-iii)

- a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
- b. The information released in response to this authorization may be re-disclosed to other parties.
- c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

 Signature of Parent/Patient/Legal Guardian

Date: _____

 Printed Name of Parent/Patient/Legal Guardian

 Relationship to Patient