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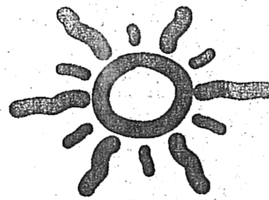

Pediatric Center P.C.
"Our focus is your child"

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CONSENT TO RELEASE INFORMATION

___Mail to address below or ___I will pick up records on ________ at___ AM/PM

PATIENT NAME:____

(street)______________________________(city)____________________(st)________(zip) ________

Phone:________________________________ Date of Birth:______________________________

I, the undersigned, hereby authorize Pediatric Center, P. C. to release to:

(name of person or institution) ____

(street)______________________________(city)____________________(st)________(zip)________

a copy of the clinical notes pertaining to my evaluation and treatment and copies of the following information as indicated (if additional information is necessary):

___History ___Progress Notes ___Physical Exam (list date)______________________

___Lab Reports ___Problem/Medication List ___Immunization Record ___X-ray Reports

I understand the information is being released for the following reason(s):

___continuing medical care ___second opinion ___transfer of medical care ___patient moving

___personal file ___referral ___other (specify) ______________________________

___insurance demands (name of ins. co. requiring change):______________________________

I give permission to release information regarding: *(initial below to specifically authorize release of this information)*

______ Substance Abuse (alcohol/drug abuse)

______ Psychiatric/Mental Health Information

______ HIV Related Information (AIDS related testing)

______ Child Abuse/Adoption

The medical record being released includes treatment from Pediatric Center, P.C. only. The law prohibits us from releasing information in the medical records from another physician, hospital or care facility. Please contact these facilities directly if you need copies of their records. This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Signature of Patient/Parent/Legal Guardian:______________________________________

Relationship to Patient:__________________Witness:____________________Date:______________

OFFICE USE: Date information sent:________________________________By:____________________