Terry Brenneman, MD • Melanie Walker, MD • Virginia Schreiner, MD • Gigi Gura, DNP, CPNP

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Child's Full Name_________________________________ Date of Birth____________________

Child's Full Name_________________________________ Date of Birth____________________

Child's Full Name_________________________________ Date of Birth____________________

____
(Street Address)

______________________________________ ______________________________________
(City, State, Zip Code) (Home Phone)

I, ______________________________, hereby authorize the use, release, and/or disclosure of Protected Health Information as described below. I understand that Pediatric Partners assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I understand there will be a fee incurred of $15.00 for release of medical records. Please allow 14 business days for all medical record requests.

I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

All Medical Records for the period of____________ to ___________ _____ Immunization Records only (No Charge)

Release From:____________________________ Release to:______________________________

Address:________________________________ Address:________________________________

____ ____

Phone:__________________________________ Phone:__________________________________

Fax:____________________________________ Fax:____________________________________

Reason for transfer/disclosure: ___ Moving ___ Transfer ___ Patient Request ___ Legal ___ Other

Transferring to another Provider: If so, please state your reason:______________________________

Patient/Parent/Guardian Signature:____Date:___/___/____

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