ALL ABOUT KIDS
Pediatrics, Inc.

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AUTHORIZATION FOR RELEASE OF PATIENT RECORDS OR INFORMATION

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Dates of Service: _____

Requesting Records From: _____Phone:_____Fax:_____

I, _____, hereby request and authorize the release of the following records:
(Patient/Parent or Legal Guardian)

_____ Complete Medical Record _____ Immunization Records _____ Physician Office Records

_____ Hospital/Surgicenter _____ Diagnostic Testing _____ Emerg. Room Visit

____ Other: _____

My Records may contain the following and, **unless crossed out and initialed,** I specifically authorize their release

_____ HIV Test Results (test for AIDS) _____ AIDS related _____ Drug or Alcohol Records

Release of information is for continuity of care unless otherwise specified: _____

Please release the above health information to:

_____

_____

_____

You are entitled to a copy of this authorization after you sign it. You have the right to revoke this authorization in writing by sending written request to the above address except to the extent that physicians listed above have relied thereon. We may not condition treatment, payment, enrollment, or eligibility for benefits on your execution of this authorization. Information disclosed pursuant to this authorization may be redisclosed by the recipient(s) and no longer protected by the federal privacy law.

Patient/Parent or Authorized Signature: _____Date:_____
Relationship to Patient: _____ Witness: _____ Date: _____