MEDICAL RECORDS RELEASE FORM

RELEASE FROM	Doctor Name	**RELEASE TO**	Doctor Name
	Address		Address
	Phone		Phone
	Fax		Fax

I authorize the release of records for the following:

Child's Name	Social Security #	Date of Birth
1.___		
2.___		
3.___		
4.___		
5.___		
6.___		

Covering the periods of service from: Birth to Present or Date of Service __________ to __________

Only records generated through The Pediatrics will be released. **(Does not include records from outside sources.)**

I request and authorize the release of information to the organization, agency, or individual named above. I understand that the information to be released may include the following condition(s):

1. Drug abuse/Alcohol abuse (federal regulation 42 C.F.R., Part 2)
2. Psychological/Psychiatric conditions
3. A test for H.I.V. (A.I.D.S.) virus
4. An A.I.D.S diagnosis and or A.I.D.S. related condition(s).

I hereby release The Pediatric Associates and personnel from all legal responsibility and liability that may arise from the records released that I have authorized above.

This authorization is valid only for the following dates ____________________ to ____________________

____

Signature of Parent or Guardian | Date Signed | Relationship to Patient

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Address of Above Parent or Guardian | Phone # of Above Parent or Guardian