



AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize _____
to release to _____
the following information from the medical records of :

Name _____ Date of Birth _____
Name _____ Date of Birth _____
Name _____ Date of Birth _____
Name _____ Date of Birth _____

Covering the period: (All) (From _____ to _____)

Mom's Name _____ 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)

This release, and all authority to disclose information pertaining to me, 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), or human immunodeficiency virus (HIV), and 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.

Signed: _____
Patient's Legal Guardian

Date: _____

Relationship to Patient

Witness: _____

