

Medical Records Release Form

I authorize _____ (individual or entity, hereinafter known as the "Organization") to release confidential health information by distributing a copy of medical records, or a summary or narrative of the protected health information to ABC Pediatrics.

Patient Name: _____ Date of Birth: _____
(Last Name, First Name, MI)

Please release the following health information:

Medical Chart Immunization Record Chart & Record Other (describe)

Limit the release of information subject to this Release Form as follows:

None One Time Use Only Limit As Indicated

The reason(s) for this release of information:

Moving Out of Area Transferring Care Locally Other (describe)

This authorization shall be in force and effective until the following event and/or date: _____

Disclosures

I understand that additional information about this Medical Release is available from the Organization and that I may obtain a copy of that information from them.

I understand that information disclosed because of this authorization may be divulged by the recipient to others and as such may no longer be protected by federal medical privacy regulations.

I understand that the Organization, and the recipient of the information, will not condition my treatment and payment on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the person listed below. I understand that a revocation is not effective to the extent that the Organization has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Releasing entity or person (the "Organization"):	
Name: _____	
Company: _____	
Street: _____	
City: _____	State: _____ Zip: _____
FAX: _____	Phone: _____

Release the protected health information to:
Dr. _____
ABC Pediatrics
3004 South WS Young Drive
Killeen, Texas 76542
Phone: (254) 634-7337 FAX: (254) 634-2592

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Relationship or Authority of Personal Representative