CHILDREN'S MEDICAL CENTER

Practice Limited to Infants, Children and Young Adults

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Authorization to Release Healthcare Information

Patient's Name: _____ Date of Birth: _____

Parent's Name: _____ Patient Contact Number: _____

I _____request and authorize to release healthcare information of the patient named above to: Person(s) being Authorized: _____.

Street Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

This request and authorization applies to:

- ◯ Healthcare information relating to the following treatment, condition, or dates (_____)
- ◯ All healthcare information
- ◯ Rx Refills
- ◯ Other: _____

Specific Circumstances

◯ Yes ◯ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

◯ Yes ◯ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed:_____

This authorization expires one year after signature and may be revoked at any time within that year.
At the discretion of the patient some information may not be disclosed.