AUTHORIZATION FOR CHARLES RIVER PEDIATRICS TO RELEASE MEDICAL RECORDS

Patient Name: _____ **Date of Birth:** _____/_____/_____

Name of Current Physician

□ CHARTOR □ DUKE □ FISHMAN □ MEISHEID □ YOON

I hereby authorize release of all medical records for the above-named patient ***EXCEPT*** those portions of the medical record checked below:

□ HIV/AIDS diagnosis and treatment □ Genetic test results □ Sexually Transmitted Diseases
□ Alcohol and Drug abuse records □ Psychiatric Health including Behavioral Medicine
□ Other: please list _____

Reason for requesting medical records (please choose at least one):
□ personal use □ moving □ new physician □ other (please explain): _____

I would like to (please check one):
□ Release medical records to self/parent and pick up at the office

OR

□ Please release records via ○ **mail** or ○ **fax** to the following person/facility:

Who will pick up the records?
Name: _____
Relationship to patient (please check one):
□ self □ mother □ father □ legal guardian
□ other: _____

Name/Facility and Address:
_____
_____
_____
Fax #: _____

Person to call when records are ready for pickup?
Name: _____ **Telephone #:** _____

Please initial indicating that you understand:

_____ I may withdraw my authorization at any time by submitting a written request to the office where I originally submitted the authorization (except to the extent action has already been taken or if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy

_____ Authorizing disclosure of health information is voluntary. I do not need to sign this form in order to assure treatment.

_____ Information released on this authorization, if redisclosed by the recipient, is no longer protected by Charles River Pediatrics

_____ The first copy of the medical record is FREE. All additional copies are $25.00

I have carefully read and understand the above and have had any questions explained to my satisfaction. I do herein expressly and voluntarily authorize the release of the medical records to the person or agency I have listed above.

_____ _____
Signature of Patient or Parent/Guardian **Printed Name** of Patient or Parent/Guardian

_____ _____
Relationship to Patient (if under 18) Signature Date

For office use only: Who picked up medical records? _____ Date: _____