AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: ____

Date of Birth: __________________________

I authorize and request From: ______________________________________
Name of Physician or Medical Facility

____
Street Address

____
City State Zip

________________ ________________
Facility Phone Number Facility Fax Number

Release Records To:

____
Name of Physicians or Medical Facility

____
Street Address

____
City State Zip

________________ ________________
Facility Phone Number Facility Fax Number

This request and authorization applies to:

□ Healthcare information relating to the following treatment, condition or dates: ____________________________________

□ All Heathcare information

□ Other: ____

I understand that my medical records of the patient for whom I am signing may include Alcohol/Drug abuse, unless otherwise provided for in the regulations. I also understand that I may revoke this consent at anytime except to the extent that prior action has been taken on it. In any event, this consent will expire ninety (90) days from the date the authorization is signed. ADVANCED PEDIATRIC CARE, PLLC, its employees, officers and physicians are hereby released from all legal liability or responsibility for the release of the records to the extent indicated and authorized herein.

________________________________ ______________________ ________________
Patient Signature or Legal Representative Relationship to Patient Date

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