Medical
Record Release Form

Patient Name:

Date of birth: / /

Sex: ☐ Male ☐ Female

Patient/Guardian Authorization

You may use or disclose the following health care information:

☐ All my health information including, but not limited to, AIDS/HIV and other Communicable Disease Information, Behavioral Health Care/Psychiatric Care, Alcohol and/or Drug Abuse Treatment, if any, unless, specifically excepted:

☐ Other

You may disclose this health information to:

Name:

Address:

Phone:

Fax:

Do you want us to ☐ fax or ☐ mail your child's medical record?

This authorization is valid for six(6) months from the date of signing and may be revoked at any time by providing written notice of revocation. I understand I cannot revoke this authorization retroactively for information already released.

Patient or legally authorized individual signature

Date

Printed name if signed on behalf of the patient

Relationship (parent, legal guardian)