ELMBROOK Pediatrics

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I HEREBY REQUEST THAT MEDICAL RECORDS BE RELEASED:

I authorize: To release to:

FOR MEDICAL RECORDS IN YOUR POSSESSION FOR PATIENT(s):

_____ _____
Name Date of Birth Name Date of Birth

_____ _____
Name Date of Birth Name Date of Birth

EXTENT OF INFORMATION TO BE SENT
(Please specify):

- ☐ Including all dates of treatment
- ☐ Only between dates of _____ to _____
- ☐ Only records of Dr. _____

REASON FOR REQUEST:

- ☐ Transfer of care
- ☐ Specialist
- ☐ Second opinion
- ☐ Insurance change
- ☐ Personal/ Other: _____

TO INCLUDE FINDINGS AND RESULTS OF:

- ☐ All medical records

- ☐ Progress Notes
- ☐ Laboratory Results
- ☐ X-Ray Results
- ☐ Immunizations
- ☐ Surgeries
- ☐ Growth Charts
- ☐ Correspondence
- ☐ Psychiatric Records
- ☐ Diagnostic Reports
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Exchange of Information between physician and school
- ☐ Other _____

THIS INFORMATION WILL BE USED FOR ONGOING MEDICAL CARE/ TREATMENT.

I authorize the release of medical information and/ or copies of my health record including, but not limited to that which involves treatment for alcohol/ drug abuse, sickle cell anemia, psychological reports, and anything to do with HIV/AIDS.

THIS AUTHORIZATION IS VALID FOR 12 MONTHS FROM DATE OF SIGNATURE.
COPY OF THIS AUTHORIZATION MAY SERVE AS ORIGINAL.

_____
Signature of patient over age 18, parent of minor or legal guardian/ representative.

_____
Date of Signature

_____
Witness signature required if patient is unable to sign but uses "X" or Marks.

_____
Date of Signature