PARTNERS 4KIDS

Authorization to Release Medical Records
(Please Print All Information Clearly)

Patient's Name: _____

Date of Birth: _____

Patient's Name: _____

Date of Birth: _____

Patient's Name: _____

Date of Birth: _____

I, the undersigned, consent to the release of medical information (records)

TO:

Partners 4Kids
9000 Lockhart Gardens, Ste. 16
St. Thomas, VI 00802

FROM:

_____

_____

_____

(P): _____ **(F):**_____

PARTNERS 4KIDS

Records to be released: (*choose one)*

- For Patients < 1 yr. old, All Records.
- For Patients 1-5 yrs. old, last 2 well visits, last 2 sick visits, all labs, all growth charts, all vaccine records and special reports.
- For Patients 6 yrs. and above, last well visit, last 2 sick visits, last 2 years of labs, last year of growth charts, and all vaccination records.
- Other: _____

Purpose of disclosure

_____

_____

_____

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for 1 YEAR from the date it is signed, or sooner if noted below. The revocation must be in writing.
4. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

Parent/ Guardian Name/Signature: Date:

_____ _____

9000 LOCKHART GARDENS SHOPPING CENTER, STE. 16 – ST. THOMAS, VI 00802-2808

Phone: (340) 77-4KIDS (5437) Fax: (888)-979-9104