



## MEDICAL RECORD RELEASE

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

As the legal guardian for this patient, I hereby authorize the release of medical information

**TO:**

Clinic/Hospital: The Children's Clinic of Winston-Salem

Address: 1400 Westgate Center Drive, Suite 206

Winston-Salem, NC 27103

Telephone: (336) 815-4890 Fax : (336) 799-3062

**FROM:**

Clinic/Hospital: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_ Fax : \_\_\_\_\_

Please release the following:

☐ **All health information (including growth charts and vaccination records)**

☐ History/Physical Exam ☐ Lab Results ☐ Discharge Summaries

☐ Progress Notes ☐ Consultation Reports ☐ Immunization record

☐ Other (specify): \_\_\_\_\_

Purpose of disclosure:

☐ Treatment/ Continuing medical care

I authorize the disclosure of medical information for the patient named above. I understand that this authorization is voluntary and may be revoked in writing at any time, unless the medical records have already been disclosed. Otherwise, this authorization shall remain valid until such time as it is revoked in writing. I understand that this authorization includes consent for information that may include substance abuse, mental health, and HIV/AIDS.

Signature of Parent or Legal Guardian: \_\_\_\_\_

Print Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date \_\_\_\_\_

Electronic Signatures: Delivery of this agreement by facsimile, email or other functionally equivalent electronic means of transmission constitutes valid and effective delivery.