COLUMBIA BASIN PEDIATRICS

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

THIS FORM MUST BE COMPLETED IN FULL BEFORE RECORDS CAN BE RELEASED

PATIENT'S NAME: _			
BIRTHDATE	LAST SOC. SEC.#	FIRST	MI PH#
RELEASE RECODS TO:			
REQUEST RECORDS	S FROM:		
() Medical Records () X-rays (Reports) () EKG's (Date) () Laboratory (Dat	(Date)e)		
READ CAREFULLY:	1		
I understand that my AIDS and/or HIV status If I have been tested, status, or drug/alcohol at to the person or entity n () yes ()no I understand that one information by the party me. I hereby release the the release of the medic ** Except for third party maximum of 90 days from PATIENT'S SIGNAT	express consent is required to a s, mental illness and/or psychiats treated or diagnosed in connections, mental illness and/or psychamed above all information or a see released, the releaser cannot be to whom I request the information or entity named above all information hereby authorized y payors of medical bills, Washom the date the release is signed.	release informati tric treatment, an etion with any sec chiatric treatment medical records: limit or control to ation be furnished and its staff from ed.	ion relating to sexually transmitted diseases and/or drug/alcohol abuse. exually transmitted disease, AIDS and/or Hont, you are specifically authorized to relea relating to such diagnosis, testing or treatment the subsequent use or dissemination of the ed. This request is a free and voluntary act is mall legal responsibility that may arise from the effectiveness of this release to a
AUTHORIZE DISCL	REACHED HIS OR HER FO OSURE RELATING TO SEX	XUAL DISEAS	
SIGNATURE			