ADETEJU OGUNRINDE, M.D, FA.A.P.
CHILDREN'S HEALTHCARE CENTER
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Phone_301-3742666 Fax_301-374-2662

AUTHORIZATION TO RELEASE MEDICAL RECORDS

RE: PATIENT'S FULL NAME_____
PATIENT'S DATE OF BIRTH_____
PATIENT'S ADDRESS _____
PATIENT'S CONTACT PHONE #_____

I _____(**parent or guardian name**) do hereby authorize:
PREVIOUS FACILTY NAME AND ADDRESS:

FAX_____
PHONE NUMBER_____

TO RELEASE

All_____Specific records_____of all dates of records:

_____HISTORY AND PHYSICALS _____CONSULTS REPORTS
_____LABORATORY REPORTS _____ RADIOLOGY REPORTS
_____IMMUNIZTION RECORDS _____ NEWBORN REPORTS
_____PROBLEM LIST SUMMARY

PURPOSE OF RELEASE

_____CHANGE OF DOCTOR _____PERSONAL _____LEGAL INVESTIGATION
_____INSURANCE _____DISABILITY _____CONTINUATION OF CARE

I hereby authorize disclosure of the health information for the above named patient. The authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to redisclosure by the person or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized may not condition its treatment of me on whether or not I sign the authorization.

_____ _____
Signature of Parent or Guardian {as above} CHC. Name and Signature
Date: Date: