LAKEVIEW PEDIATRICS, LLC

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Medical Records Release Authorization form

PATIENT'S NAME _____ D.O.B. _____/_____/_____

PARENT/GUARDIAN_____

(Relationship) (Phone #)

I hereby give _____ (name of doctor or facility) permission to release all records as indicated below, to _____ (name of doctor or facility, or self).

These records will be released for the purpose of:

Patient Care Specialist Attorney/Client Insurance
School Changing Practices Moving
Personal Use Other: _____

New Contact Information for Family:

Name:_____
Address: _____
Phone: _____
Email: _____
Effective Date: _____

Release Information to the following Person or Organization:

Name: _____
Address: _____
Phone: _____

Preferred Delivery Method

Fax: _____
Email: _____

The records to be released will include (please check only one of the following two options):

1. O Entire Medical Record **including** diagnoses and treatment of behavioral and/or mental health, HIV/AIDS related health information, pregnancy records, drug/alcohol diagnosis, treatment, and/or referral information, information about sexually transmitted disease, and birth control records.
2. O **Please release only the following:**

- □ Immunization Records
- □ Growth Charts
- □ Medication List
- □ Lab Results
- □ Imaging Results
- □ Other: _____
- □ Behavioral and/or mental health records
- □ Drug/alcohol diagnosis, treatment, and/or referral information
- □ HIV/AIDS related health information and/or records
- □ Information about sexually transmitted disease
- □ Pregnancy records
- □ Birth control records

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.
I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of healthcare is solely for the purpose of creating protected health information for disclosure to a third party.
I understand that this authorization is valid for one full year unless a written letter of termination is received.
I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office. Absent such revocation, the Authorization for Release of Confidential Health Information will terminate on (date) _____/_____/_____.

I understand that there is a fee per chart for these records and will pay at the time of the request. I also understand that once the medical records are released for the purpose of switching physicians or seeking other medical care, that I am only able to receive emergent care from Lakeview Pediatrics for 30 days and I am responsible for seeking medical treatment elsewhere thereafter.

_____ _____ _____/_____/_____
Signature of Parent/Legal Guardian Relationship Date

If this patient is 12 years old or older, the patient must also sign below to authorize the release of this information.

_____ _____/_____/_____
Patient Signature (If 12 years or older) **Date**
