-Beyond Care Pediatrics Release Of Information Forms-

Beyond Care Pediatrics
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Medical Records Fax: (800)557-1226
Bernard Douglas, MD

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

City, State, Zip _____

Home Phone#: _____ Cell/Home

Medical Records to release:

____All Records ____Specified Time Period:_____

Specific Records, Please List:_____

I authorize the release of my medical records from the Physician/Medical office(s) list below:

_____

Please send the records I specified above to the following Provider/Medical Office:

_____

_____

_____

I understand the above named individual's health information may include information relating to sexually transmitted diseases, genetics, sexual activity including contraceptive methods, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) where applicable. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse in accordance to 42 CFR Part 2

Printed Name_____Relationship:_____

Patient/Guardian Signature_____ Date: _____

**This Authorization is Valid for 365 days from date of signing.