Mountain View Pediatrics, PLLC

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AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL MEDICAL INFORMATION INCLUDING HIV RELATED INFORMATION

Patient Name: _____

Date of Birth: _____

Period of Time: From: _____ To: _____

Reason for Release: _____

Release of Information To: _____

_____

_____

From: _____

_____

_____

I authorize Mountain View Pediatrics to ____Obtain____Release medical records, x-ray films, x-ray reports, and other information regarding the hospitalization, and/ or outpatient care concerning the above named patient for the period specified. This authorization includes confidential information such as: psychological or psychiatric impairment, drug use and/or alcoholism, Acquired Immunodeficiency Syndrome (AIDS) and test for or infection with Human Immunodeficiency Virus (HIV).

I understand that this authorization will automatically expire six (6) months from the date below; unless otherwise specified.

X_____ X_____

Signature of Patient (or person authorized to consent for patient)

Date

X_____ X_____

Relationship to patient

Witness

Staff: Request completed by- Initials and date _____