KIDS COVE
PEDIATRICS

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Authorization for Release of Medical Information

Patient Name:_____ **DOB**: _____

I, _____ , hereby authorize the release of medication information

TO: Doctor/Clinic/Hospital: _____
Address: _____
Telephone: _____ Fax: _____

FROM: Doctor/Clinic/Hospital: _____
Address:_____
Telephone:_____ Fax:_____

Please release the following:
___ All health information (including growth charts and vaccination records)
___ Developmental Reports
___ History/Physical Exam
___ Discharge Summary
___ Diagnostic Test Reports
___ Progress Notes
___ Consultation Reports
___ Radiology Reports
___ Laboratory Results
___ Pathology Reports
___ Birth Records/Newborn Report
___ Other (specify):_____

I consent to the release of information related to HIV/AIDS or infection with any other communicable diseases and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records
____ Yes, I consent to the release of this information.
____ No, I do not consent to the release of this information.

Purpose of disclosure:
____ Transfer of Care
____ Treatment/Continuing Medical Care
____ Specialist Referral
____ Other (specify):_____

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Signature of Parent or Legal Guardian: _____ Date:_____

Print Name: _____

Relationship to Patient: _____