Whole Child Pediatrics

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____

(**PRINT** patient's full name) (birth date: mo/day/yr)

_____ _____

(street address) (social security number)

_____ _____

(city, state, zip code) (phone)

At the request of the individual, I _____, (patient's name or parents name if patient is ***under*** 18) do hereby authorize _____ (name of facility) to release:

RECORDS ARE REQUESTED FOR THE FOLLOWING DATE/TIME PERIOD: _____

_____ **entire chart** _____ laboratory reports _____ history & physical _____ progress notes

_____ radiology reports _____ last 2 years only _____ operative notes _____ other (be specific): _____

_____ I do _____ I do NOT authorize release of information related to HIV (Human Immunodeficiency Virus) or AIDS (Acquired Immunodeficiency Syndrome), psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO:

_____

parent or legal guardian of patient (if patient is under 18 years old)

_____

street address

_____

city, state, zip code

PURPOSE OF DISCLOSURE:

_____ referral to specialist _____ disability determination _____ leaving practice

_____ legal investigation _____ workers comp _____ relocating

_____ insurance _____ personal _____ other (be specific) _____

I hereby authorize disclosure of the health information for the above named patient. This 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 re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may no condition its treatment of me on whether or not I sign the authorization.

_____ _____

Signature of individual or guardian or personal representative of patient's estate **date**
(Power of Attorney must be on file with office or accompanying this request)

_____ Please **mail records** as a CD to address listed above ($15 per patient chart)

_____ Please **email records** as a PDF file ($10 per patient chart): _____

(email address)

Please provide me with the medical records described above. I understand and agree that:

- I must provide a valid email address, either my own or that of my designated recipient.
- My records will be provided as Adobe PDF files.
- I will receive an email from WCP containing instructions for accessing my records.
- Payment is requested at the time the request is submitted.

Signature _____ Date _____