

**Authorization to Release Medical Information to
Great Destinations Pediatrics, PC**

Patient Information:

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Address: _____

Phone: _____

I hereby authorize Great Destinations Pediatrics, PC to **RECEIVE** photocopies of medical records concerning the above named patient(s) **FROM:**

Practice/ Company or Person(s) authorized to release records:
Name: _____
Address: _____

Phone: _____ Fax: _____
For the purpose of: _____

(Check all that apply)

Records to be included:

_____ All Medical Records

_____ Copies of Medical Records for the Period: _____/_____/____ to _____/_____/____
Mo Day Year Mo Day Year

_____ Copies of Information described below for the Period: _____/_____/____ to _____/_____/____
Mo Day Year Mo Day Year

_____ Immunization Record

_____ Consult Reports

_____ Lab, X-Ray

_____ Other (Please Specify) _____

_____ The following information should **not** be released (Please Specify) _____

In accordance with federal regulations, I hereby consent to the release of records pertaining to treatment/diagnosis of the following should records contain this information: Condition relating to drug and/or alcohol abuse, condition related to psychiatric/psychological treatment, AIDS/HIV, and communicable diseases.

This request will remain in effect for 1 year from the date of this request.

I understand that I may revoke this authorization at any time in writing except to the extent that action based on this authorization has already been taken.

Patient or legally authorized individual signature

Date

Printed name if signed on behalf of the patient

Relationship (parent, legal guardian, etc...)