

LAKEVIEW PEDIATRICS, LLC

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Medical Records Release Authorization form

PATIENT'S NAME _____ D.O.B. ____/____/____

PARENT/GUARDIAN _____
(Relationship) (Phone #)

I hereby give _____ (name of doctor or facility) permission to release all records
as indicated below, to _____ (name of doctor or facility, or self).

These records will be released for the purpose of:			
Patient Care	Specialist	Attorney/Client	Insurance
School	Changing Practices		Moving
Personal Use	Other: _____		
Release Records to the following Person(s) or Organizations:			
Name: _____			
Address: _____			
Phone/Fax: _____/_____			
Email: _____			

New Contact Information for Family:
Name: _____
Address: _____
Phone: _____
Email: _____
Effective Date: _____

The records to be released will include (please check only one of the following two options):

- Entire Medical Record **including** diagnoses and treatment of behavioral and/or mental health, HIV/AIDS related health information, pregnancy records, drug/alcohol diagnosis, treatment, and/or referral information, information about sexually transmitted disease, and birth control records.
- Please release only the following:**

<input type="checkbox"/> Immunization Records	<input type="checkbox"/> Behavioral and/or mental health records
<input type="checkbox"/> Growth Charts	<input type="checkbox"/> Drug/alcohol diagnosis, treatment, and/or referral information
<input type="checkbox"/> Medication List	<input type="checkbox"/> HIV/AIDS related health information and/or records
<input type="checkbox"/> Lab Results	<input type="checkbox"/> Information about sexually transmitted disease
<input type="checkbox"/> Imaging Results	<input type="checkbox"/> Pregnancy records
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Birth control records

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.

I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of healthcare is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that this authorization is valid for one full year unless a written letter of termination is received.

I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office. Absent such revocation, the Authorization for Release of Confidential Health Information will terminate on (date) ____/____/____.

I understand that there is a fee per chart for these records and will pay at the time of the request. I also understand that once the medical records are released for the purpose of switching physicians or seeking other medical care, that I am only able to receive emergent care from Lakeview Pediatrics for 30 days and I am responsible for seeking medical treatment elsewhere thereafter.

Signature of Parent/Legal Guardian Relationship ____/____/____ Date

If this patient is 12 years old or older, the patient must also sign below to authorize the release of this information.

Patient Signature (If 12 years or older) Date

For office use only

Received: ____/____/____ Paid: ____/____/____ Approved: ____/____/____ Entered: ____/____/____
Paid amount: _____ Confirmation receipt: ____/____/____ Mailed: ____/____/____
Balance/records\$ ____/____ Upcoming appt/fax/address validated ____/____/____