Release of Medical Records
Provider to Provider

Date:_____

I hereby authorize _____

to release to_____

the following information from the medical records of:

Name:_____ DOB:_____
Name:_____ DOB:_____
Name:_____ DOB:_____
Name:_____ DOB:_____

Covering the period: (All) (From_____to_____)

Guardian's Name:_____ DOB:_____

PLEASE SEND US ONLY:
Immunization information, Problem List and Growth Charts
Copy of complete medical records
Lab & copy of X-Ray reports
Birth records and Infant Screen (PKU)

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written authorization unless otherwise provided for in the regulations. I also understand that this authorization may be revoked in writing at any time, and that the disclosed information may be subject to disclosure by the recipient although discouraged. I also understand that this authorization gives permission to transmit the requested records electronically. This authorization includes the electronic submission of any and all requested information from your insurance company for billing purposes. If another party receives them in error, I absolve this clinic and the employees of this clinic of any and all liabilities relating to such submission of said records.

This authorization expires on _____ unless revoked in writing prior to date.

Signed:_____Relationship to Patient:_____

Print Name:_____Witness:_____

Prohibition on Re-disclosure: This information has been disclosed from records whose confidentiality is protected by federal law. Federal regulations (42CPRPart2) prohibit recipients from making any further disclosure of the information except with the specific written consent of the patient. A general authorization for the release of information if held by another party is not sufficient for that purpose.