GROWING WITH YOU
PEDIATRICS

Authorization to Release Medical Information

Patient's Name: ____________________________ Date of Birth: _____/_____/_____

NEW PATIENT RELEASING INFORMATION FROM:

Clinic: ____

Address: ____

Fax: ____

Email: ____

Phone: ____

EXISTING PATIENT RELEASING RECORDS TO:

Clinic: ____

Address: ____

Fax: ____

Email: ____

Phone: ____

Please release the following information:

______ Complete medical record

_______________________Please list any items that you do not want released from the record.

Purpose of the release of medical information

______Transfer of care ______ Ongoing medical care

☐ *I understand the information to be disclosed may include information relating to a diagnosis and or treatment of mental illness, alcohol or drug abuse, STD or HIV testing results, developmental disabilities, and genetic testing.*

This authorization can be revoked in writing at any time.

Signature: ____ Date: _________________________

Growing With You Pediatrics
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