

Pediatric Associates of Franklin, P.A.

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MEDICAL RELEASE FORM

Patient's Full Name: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

Patient's Birth Date: \_\_\_\_\_

to release copies to

to obtain copies from

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

The following Information for date of service: \_\_\_\_\_

- Discharge Summary     History & Physical     Psychiatric Evaluation     Emergency Records
- Lab Reports     Medication Record     Psychological Testing     Physicians Orders
- Progress Notes     Treatment Plan     X-Ray Reports     Face Sheet
- Immunization Records
- Complete chart from dates: \_\_\_\_\_

This information is requested for the purpose of:

- Continued Treatment     Insurance     Attorney     Personal     Other \_\_\_\_\_

To be:     Picked Up     Mailed     Fax to phone Number: \_\_\_\_\_

I do hereby consent and authorize you to release copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics which are a part of my medical records. PLEASE NOTE: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information; and any information relating to pregnancy, sexually transmitted diseases, HIV testing, AIDS, and any AIDS-related syndromes. It also includes any information concerning cancer, cancer testing and cancer results. I agree that a copy of this release or a fax of this release shall be as valid as this original release. I understand that this authorization may be revoked in writing and the written revocation must be delivered to the Medical Records Dept., revocation will not be effective for the disclosure of records whose release I had previously authorized, or where other action had been taken in reliance on a valid authorization. Please send copies of all requested information as soon as possible to the address listed below:

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Witness: \_\_\_\_\_

EXPIRATION DATE: This authorization will expire on (date no later than one year from now) \_\_\_\_\_