Childcare Associates

Pediatric & Adolescent Medicine
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Medical Records Release

Name:____
Last   *First*   *Middle Initial*

DOB:____/____/____ Home Phone:__________________ Other Phone:__________________

Date of Request: __________________________ Date Needed: ________________________

PLEASE RELEASE RECORDS:

FROM:
____
____
____
____

TO:
____
Address __________________________
City/State __________________________
Phone&Fax __________________________

What records do you want sent to/from Childcare Associates:
(check all that apply)

◯Health summary and immunization record   ◯Information from last 2 years of care   ◯ All

For the purpose of   ◯Healthcare   ◯Immigration   ◯ Personal   ◯Transfer of Care

The information authorized for disclosure may relate to: (initial all that apply, without specific authorization none of this information will be disclosed.)
◯ Alcohol/Drug Abuse   ◯ Psychiatric Care   ◯ HIV/AIDS   ◯ Sexually Transmitted Diseases, Testing and Results
◯Communicable Diseases   __________
Initials

I understand these facts about the release of information by Childcare Associates:

1. Consent for release of information is not required as a condition of treatment.
2. This authorization may be revoked at any time except that information that has been disclosed prior to the date of revocation.
3. Only information necessary to fulfill the purpose(s) stated above may be released.
4. I understand that if I authorize disclosure of protected health information, the recipient may further disclosure this information and federal law will not protect it.
5. I understand that I have the right to inspect or copy the information I am consenting to release. A copying fee may apply.
6. Once this authorization has expired we will no longer use or disclose your health information.
7. I am entitled to receive a copy of this signed authorization. I have received a copy. Initial here:________
8. I understand that information may be released by any acceptable means, including by fax.
9. This authorization will expire in 6 months (180 days) from the date below or on:____________
10. A copy of this release is as an original (e.g. fax).

Date:__________   ______________________________   ______________________
Signature of patient/authorized representative   *relationship if not patient*

Witness:______________________________ I.D. Checked (please initial):__________

Interpreter's statement:

I have translated the information of this form orally to the individual in _______________ (language) and explained its contents to him/her. To the best of my knowledge and believe he/she understood this explanation.
Date:__________   ______________________________
Interpreter's signature

For office use only: Release of records approved by:______________________ Date:__________________