Children's Medical Group, P.A.

MEDICAL RECORDS RELEASE FORM

By signing this authorization, I authorize Children's Medical Group to release and disclose protected health information about me to:

_____
Name of entity to receive information

_____
Address

_____
City/State/Zip

_____
Phone number

This authorization permits Children's Medical Group to use and/or disclose the following individually identifiable health information about me: (specifically describe the information to be used or disclosed, such as date(s) of services, types of services, level of detail to be released, origin of information, etc.):

_____
_____

This information is necessary for the following purpose:

___ Continue patient care ___ Insurance ___ Other (specify)
___ Personal use ___ Attorney / Legal

I understand that the information in my child's health record my include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

There is a $25.00 minimum fee that applies per patient if you are requesting / transferring medical records from CMG.

Signed by: _____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Patient's Date of Birth

_____ _____
Print Name of Patient or Legal Guardian Date

_____
Email address to be used for patient portal access

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION

OFFICE USE:
date completed: _____ initials: _____