AUTHORIZATION FOR RELEASE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____

Patient Name:_____ Date of Birth:_____

Release Records to:

Parent/Physician/Facility: _____

Address: _____

City/State/Zip: _____

Phone# _____ Fax# _____

Request Records from:

Physician/Facility: _____

Address: _____

City/State/Zip: _____

Phone# _____ Fax# _____

Establishing with:_____ Dr.Wyatt_____Dr.Beebe_____Dr.Grooms_____Dr.Boon_____Dr.Oum

Please release the following information:

___ All Records ___ Shot Record ___Other (Specify)

This authorization will expire 1 year from today's date unless otherwise stated.

There will be a charge for the release of medical records $1 per page for the first 5 pages and $0.25 for each additional page.

I understand that the information in my child's health record may include information relating to sexually transmitted disease, 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. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature_____ Relationship_____

Phone # _____ Date _____