Wadsworth PEDIATRICS

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name(s): _____ Birth date: _____/_____/_____

_____ _____/_____/_____

_____ _____/_____/_____

_____ _____/_____/_____

I, the undersigned, hereby to release copies of the medical records of my minor child to:

Doctor's/Clinic Name: _____

Address: _____

_____

I understand and acknowledge that the medical record may contain mental health, substance abuse, and/or HIV information and I expressly consent to the release of such information.

I understand that if the person(s) or class(es) of persons to whom the records are being released are not health care providers, health plans, or health care clearinghouses covered by the Federal privacy regulations; the protected health information they receive may be further used or disclosed by them and may no longer be protected by the Federal privacy regulations.

_____ ___/___/_____ _____

Signature of Parent/Legal Guardian/Patient Date Relationship

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