Wadsworth PEDIATRICS

AUTHORIZATION TO

RELEASE MEDICAL INFORMATION

Patient's Name(s): _____ Birth Date: _____

_____ Birth Date: _____

_____ Birth Date: _____

I, the undersigned, hereby authorize Wadsworth Pediatrics to release copies of the medical records of our minor child(ren) to:

Doctor's/Clinic Name: _____

Address: _____

_____

Fax Number: _____

I understand and acknowledge that the medical records may contain mental health/alcohol/drug abuse and/or HIV information and I expressly consent to the release of such information.

I understand that if the person(s) and class(es) or 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 not be protected any longer by the Federal privacy regulations.

_____ _____ _____

Signature of Parent/Guardian/Patient Date Relationship

William F. Oehlenschlager, MD, PhD
Kimberly A. Blair, MD
Julie A. Reynolds, MD
Shelli I. Reed, CPNP

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