Old Harding Pediatric Associates
ESTABLISHED 1937

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

I hereby authorize (practice requesting records **FROM**)

_____ **Old Harding Pediatric Associates**

_____ **(Other Doctor) Name:**_____ **Phone:**_____

and its physicians employees and agents to release or disclose to the below-named recipient all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

Patient Name: _____ **Date of Birth**: _____
Patient Name: _____ **Date of Birth**: _____
Patient Name: _____ **Date of Birth**: _____

Forwarding Address for future mail:

_____

I hereby authorize the release of medical records TO:

Doctor's Office/Name:_____

Address: _____

_____

Phone Number: _____

Purpose of Release: _____ Moving _____ Changing Doctors _____ Personal Use

This request and authorization applies to:

_____ All Medical Records _____ Specific Date(s) of Service_____

*****All records will be sent electronically unless otherwise specified. If you wish to have them printed to paper please note here: _____

If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.

_____Substance abuse _____Psychological or psychiatric treatment _____HIV/AIDS/STD

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing this authorization.

_____ _____

Signature of Patient or Authorized Representative Date Signed

_____ _____

Relationship to Patient Contact Phone Number

***The authorization will expire one year from the date signed**