Authorization to Release Medical Records & Information

Patient Name: _____ DOB: _____

Patient Address: _____

City: _____ State: _____ Zip: _____ Contact #: ( ) _____

*I hereby authorize the following facility/institution/physician to release medical records **to / from**:*

Mill Valley Pediatrics, Inc.
17853 State Route 31
Marysville, Ohio 43040
Office (937) 578-4210 **Fax** (937) 578-4220

*To promote continuity of care, these medical records may be released **to / from**:*

Physician / facility: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: ( ) _____ Fax: ( ) _____

Records to be released:

____ **Complete Chart**	____ Growth Chart	____ Operative Reports
____ Discharge Summary	____ Progress Notes	____ Radiology/Lab Reports
____ Immunization Record	____ Specialists	____ Other: _____

Authorized Information will be used and/or disclosed for the following purposes:

____ Request of the parent/legal guardian for personal records

____ Follow up care with specialist(s)

____ Transferring to another practice

Please explain: _____

____ Other: _____

I expressly consent to the release of the information designated above. I understand and acknowledge that my authorization includes all parts of the records as states, including treatment for mental illness, alcohol, drug abuse, and HIV/ARC/AIDS. A copy of this authorization is as valid as the original. This release is valid for 180 days from date of signature and may be revoked at any time in writing by the patient or legal guardian. This information has been disclosed to you from records whose confidentiality may be protected by federal law. Federal regulations (42 CFR Part 2) prohibits you from making further discloser of it without specific written consent of the persons to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. Copies of medical records not intended for medical use may be subject to a minimal charge.

Signature of Parent or Legal Guardian: _____ **Date:** _____

Witness: _____ Date: _____