Authorization For the Release of Medical Information

Premiere Pediatrics
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Email: medicalrecords@premiere-pediatrics.com

Patient Name: ____ Date of Birth: _____________________________

I hereby authorize the release of my child's medical records and/or health information as specified below:

Releasing Provider/Office:_____________________________
Phone: (______) __________-_________
Fax: (______) __________-_________
Email:____

Person(s) listed above is authorized to release □ **photocopies OR** □ **digital files** of my child's medical records and/or health information. Please **DO NOT** fax medical records over **25 pages**. We will not fax records larger than **25 pages** to another facility.

To the following named individual or organization: ____

□ Pickup □ Mail □ Email

Address: ____
____
Phone/Fax: (_______) ______________-_________________
Email: ____

This information will be obtained, used, or disclosed for the following purpose:
□ Continued treatment □ Personal Use □ Transfer
□ Other____

Information to be released:
□ Complete Record □ Immunization Record □ Records during: ___/____/____-___/____/___
□ Records concerning____

I agree to pay $0.50 per page for paper records or $0.30 per page for records released in electronic format, plus the cost of postage, if applicable. Digital records will be charged a maximum of $25.00 and paper records a maximum of $35.00. I agree to pay prior to receiving my records, and understand that these charges apply for records that are requested and not picked up within a timely manner.
*Any requested records left unclaimed for 2 months will be discarded. *
Fees may be waived if we are mailing records to another physician.

I further release Dr.__________________________ from responsibility for any deleterious effect the release of my child's clinical medical records may have upon myself or others both now and in the future. I personally accept all responsibility for my own distribution and interpretation of medical information contained therein and I hold blameless the Office of Premiere Pediatrics PLLC, for conclusions or opinions drawn from said records without professional knowledge, assistance, or review.

By State Law, you must be advised that: the information authorized for release may include records which may indicate the presence of communicable or venereal diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus also known as Acquired Immune Deficiency Syndrome (AIDS).

I realize by release and/or receipt of these records that I am accepting responsibility for the protection of my own right of medical record confidentiality.

______________________________ ______________________________ ____________________
Parent/Patient/Guardian Printed Name | Signature of parent/patient/ guardian | Date

______________________________ ______________________________ ____________________
Pickup Printed Name | Signature of pickup person | Date Picked Up

Date Received_________________ Date Released____/_____/______