Authorization for Release of Medical Records

☐ I Hereby Authorize Central + Priority Pediatrics to **REQUEST** information **FROM:**

Clinic Name _____ Clinic Address_____

Clinic Phone #_____ Fax#_____

☐ I Hereby Authorize Central + Priority Pediatrics to **RELEASE** information **TO:**

Clinic Name _____ Clinic Address_____

Clinic Phone #_____ Fax#_____

Patient Name _____DOB _____

Patient Name _____DOB _____

Patient Name _____DOB _____

Patient Name _____DOB _____

Records to be released:

☐ History and Physical ☐ Laboratory Report ☐ X-Ray Report ☐ Progress Notes ☐Other (specify dates of service)_____

☐ Office notes for past 2 years (includes all items above)

I authorize the release of information relating to:

☐ Alcohol/Drug Abuse Evaluation/Treatment ☐ HIV/AIDS testing/Treatment

☐ Psychiatric Evaluation/Treatment

Purpose of Release:

☐ Continuing care for on going treatment ☐ Transfer of Care ☐ Insurance ☐ Personal (copy and retrieval fees may apply)

Statement of Authorization:

- This authorization expires (1) year after the date of my signature below
- I understand that Central Pediatrics and Priority Pediatrics will not condition my treatment, payment, enrollment, or eligibility or benefits on my signing this authorization.
- Except to the extent that action has already been taken, I understand that I may revoke this authorization at any time by giving by giving written notification to Medical Records. A photocopy/fax of this authorization will be treated in the same manner as the original.
- I do not authorize further release to any third party. I understand that once information is sent as specified in this authorization, Central Pediatrics and Priority Pediatrics, and their employees and physicians cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

_____

Signature of legally authorized representative/patient Date

_____

Print Name Phone # Relationship to Patient

□ 9680 Tamarack Rd, Ste 100, **Woodbury**, MN 55125 / 651.738.0470 FAX: 651.738.5907

□ 2436 Cleveland Ave North, **Roseville**, MN 55113 / 651.645.4693 FAX: 651.645.6503

central+ priority PEDIATRICS

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