**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I understand that my child(s) medical records are confidential and cannot be disclosed without my written authorization, except otherwise provided for by law. I hereby voluntarily authorize TOTS 2 TEENS

(Patient Name) (DOB)

_____ _____
_____ _____
_____ _____

The information specified below may be released to:
Name:_____
Address:_____ City:_____
Zip Code:_____ Telephone#:_____ Fax:_____

The specific purpose(s) for this disclosure is/are:
(_) my personal use
(_) sharing with other healthcare providers
(_) other (please describe)_____

**(_) I WANT (_) I DO NOT WANT** (Please check one) you to INCLUDE information pertaining to the diagnosis and/ or treatment of HIV testing, AIDS, psychiatric illness, and alcohol and/ or chemical and dependency if any.

**SPECIFIC INFORMATION TO BE RELEASED:** (Please check all that you are requesting to be released)

_____Complete Medical Records for this Office _____Immunization Records Only
_____History & Physical _____Diagnostic Testing & Results
_____Other (Please List)_____

- I understand that I may revoke this authorization at any time by notifying the office in writing at **ATTN: Practice Manager, Medical Record Request**, of my intent to revoke this authorization, and that such revocation will not have any effect on any actions taken by the office before revocation
- I understand this authorization **expires180 days** from the date signed, unless otherwise revoked.
- I understand that once the above information may not be protected by federal privacy laws or regulations.
- I understand that **I may be charged for the copies** of my child's medical record, which I request for myself or for the use by others. I also understand **fees for copies are due and payable before copies are released.**
- I understand that a photocopy or facsimile of this authorization is as valid as the original.

Signature:_____ Date:_____
Printed Name:_____ Relationship to Patient:_____