Hartman
PEDIATRICS

Authorization for Release of Medical Information

Patient Name:_____DOB:___/___/_____

I,_____hereby authorize the release of medical information
TO:

Hartman Pediatrics LLC
550 30th Avenue, Suite 2, Moline, IL, 61265
Phone: 309-249-0069, Fax: 309-524-4654

FROM:
Doctor/Clinic/Hospital:_____

Address: _____

_____

Telephone:_____ Fax:_____

Please release the following:

__**Vaccine records, growth charts, most recent well child exam note**

___Other (specify): _____

I consent to the release of information related to HIV/AIDS or infection with any other communicable diseases and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records

___ Yes, I consent to the release of this information.
___ No, I do not consent to the release of this information.

Purpose of disclosure:

___ Treatment/ Continuing medical care

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Signature:_____Date:____/____/____

Print Name:_____Relationship to Patient:_____