Hartman
PEDIATRICS

Authorization for Release of Medical Information TO Hartman Pediatrics

Patient Name: _____ DOB: _____/_____/_____

I, _____authorize the release of the following medical records to Hartman Pediatrics by fax at 309-524-4654:

_____ Limited record to include most recent well visit note, vaccine records, labs, growth charts

_____ Complete copy of record

*** If these records contain any information about HIV/AIDS, cancer, drugs/alcohol, mental health or sexually transmitted infections, I authorize disclosure of this information.

_____I am transferring all further care and request to release records to Hartman Pediatrics from the facility listed below:

Doctor/Clinic: _____

Address: _____

Phone: _____ Fax: _____

I understand that this request may take to 30 days to complete under HIPPA guidelines. I may revoke this authorization in writing at any time.

Parent/Guardian Signature: _____Date: _____