Bee Well Pediatrics

Medical Information Release and Request Form

Patient Name: Date of Birth:

Authorization to Release and Obtain Healthcare Information

This form authorizes the release and/or request of confidential health information as specified below. Please indicate whether this form is for releasing information from Bee Well Pediatrics, obtaining information for Bee Well Pediatrics, or both.

Direction of Information

☐ Obtain information for Bee Well Pediatrics from the following entity

Entity/Provider Information:

Previous Provider Name: Phone Number: Fax Number:

Address City State Zipcode

Information to be Released/Obtained

Type of Information

☐ Medical Records
☐ Billing Records
☐ Immunization Records
☐ Entire Health Record
☐ Other (Please specify)

Purpose of the Release/Request

☐ Continued Medical Care
☐ Insurance/Billing
☐ Legal Purposes
☐ Personal Use
☐ Other (Please specify)

Right to Revoke

You may revoke this authorization at any time by submitting a written request to Bee Well Pediatrics. However, revocation will not apply to information that has already been released or obtained in response to this authorization.

Notice

Information disclosed under this authorization might be redisclosed by the recipient and may no longer be protected by federal privacy regulations.

Signature of Patient or Legal Guardian

- **I authorize the release and/or request of my healthcare information asdescribed above. I understand that this consent is voluntary and that I may refuse to sign this authorization.**

Printed Name of Patient or Legal Guardian:

Signature: Date