**AUTHORIZATION TO RELEASE MEDICAL INFORMATION FROM COASTAL PEDIATRIC CARE**

I authorize the below named health care provider to release the information or records specified.

PROVIDER NAME and ADDRESS PATIENT NAME and DOB

|  |  |
| --- | --- |
|  |  |

( ) ALL MEDICAL RECORDS ( ) Consultation Reports ( ) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

( ) Office Notes ( ) Lab Results ( ) Radiology Reports ( ) Growth Charts

( ) SUMMARY OF CARE ( ) IMMUNIZATIONS ( ) LAST WELL VISIT/PHYSICAL

Reason records are being released from CPC: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This information will be used for the purpose of: ( ) New Primary Care Doctor ( ) Other Activities

( ) Investigating an allegation of abuse ( ) Legal Representation ( ) Providing Advocacy Services

I understand that I can revoke this authorization at any time by writing to the health care provider. Revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I also understand that: (1) I am not required to sign this authorization and that my health care, or payment for care, will not be affected by my refusal, (2) I am entitled to receive a copy of this authorization, and (3) a copy of this authorization may be utilized with the same effectiveness as an original.

Patient or legal guardian signature (if under 18 yrs): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_