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AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient Name: _____ **Date of Birth**: _____

Patient Name: _____ **Date of Birth**: _____

Patient Name: _____ **Date of Birth**: _____

Patient Name: _____ **Date of Birth**: _____

I hereby authorize the release of my child's medical records to Canadian Valley Pediatrics from:

DOCTOR: _____

ADDRESS: _____

CITY: _____ **STATE**: _____ **ZIP CODE**: _____

PHONE: _____ **FAX**: _____

PLEASE INCLUDE VACCINE RECORD

For the purpose of: (__) Continuing or transfer care (__) Vaccine record (__) Legal matters

_____Release information concerning the following dates: from _____ to _____

_____Complete medical record

_____Other (specify): _____

I (__) **DO** or (__) **DO NOT** (check one & initial here _____) consent to the release of information relating to psychiatric or psychological testing or treatment, alcohol and/or drug abuse diagnosis/treatment, or HIV (AIDS) testing.
I, the parent/guardian, agree that a photocopy or fax of this authorization may be considered valid, this authorization shall be valid for 100 days from the date of signature, and that this authorization can be revoked in writing at any time prior to the expiration date. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected.

Relationship to Patient (circle one): ***self*** ***mother*** ***father*** ***guardian***

Parent/Guardian Printed Name: _____

Signature: _____ **Date**: _____