AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

from Canadian Valley Pediatrics, Dr. Dina Bowen, M.D.
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I hereby authorize the release of my child's medical records ***from*** Canadian Valley Pediatrics to:

PERSON: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____ FAX: _____

For the purpose of: (__) Continuing or transfer care. (__) Proof of immunization. (__) 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, email 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. I hereby release and hold harmless Canadian Valley Pediatrics, Dina M. Bowen, MD, PLLC from all liability and damage resulting from the lawful release of my Medical Records.

Patient's name: _____ **Date of birth:** _____

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Patient's name: _____ **Date of birth**: _____

Patient's name: _____ **Date of birth**: _____

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

Parent/Guardian Printed Name: _____Signature: _____

Date: _____