Authorization for Release of Medical Information

Patient name:_____

Date of Birth:_____

☐ I authorize Midtown Pediatrics to release information to:	☐ I authorize Midtown Pediatrics to obtain information from:
Provider/Facility:_____ Address:_____ City, State, Zip:_____ Phone #:_____ Fax #: _____	Provider/Facility:_____ Address:_____ City, State, Zip:_____ Phone #:_____ Fax #:_____

Purpose for this request: (check one)

☐ Transfer of Care ☐ Specialists ☐ Personal ☐ Other _____

Requested Information:

☐ Entire Medical Record
☐ X-Ray/Radiology Reports
☐ Mental Health Records
☐ Immunization Records
☐ Billing Records
☐ Other:_____
☐ Most recent progress note
☐ Lab/Pathology Reports

☐ I will pick up copies of my records (see charges below)
☐ Please fax or mail my records to the Physician/Facility listed
☐ I authorize MTP to obtain records electronically from Electronic Health Record

I hereby request access to the protected health information in my health record. I understand:

• I may revoke this authorization at any time by providing my written revocation to the address at the top of this form. My revocation will not apply to information already retained, used or disclosed in response to this authorization. Unless sooner revoked, the automatic expiration date of this authorization will be 36 months from the date of signature.

• The information authorized for release may include records that may indicate the presence of a communicable disease or non-communicable disease and/or may indicate that I have been treated for a psychological or psychiatric condition(s).

• There will be a charge for printed records, $1.00 for the first page and .50¢ for each additional page plus mailing costs. There will be no charge for records faxed to another physician and no charge for updated immunization records.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Relationship to Patient

Midtown Pediatrics

Charity Pollak MD

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