Childcare Associates

Pediatric & Adolescent Medicine

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Medical Records Release

Name: _____ _____ _____
Last **First** **Middle Initial**

DOB: ___/___/_____ **Home Phone:** _____ **Other Phone:** _____

Date Requested: _____ **Date Needed:** _____

Please Release Records:
From:
_____
_____
_____
_____

To: _____
_____
Address: _____
City/State: _____
Phone & Fax: _____

What records do you want sent to/ from Childcare Associates:
(Check all that apply)

- ☐ Health summary and immunization record
- ☐ Information from the a last 2 years of care
- ☐ All

For the purpose of:

- ☐ Healthcare
- ☐ Immigration
- ☐ Personal
- ☐ Transfer of care

The information authorized for disclosure may relate to: (Initial all that apply without, specific authorization none of this information will be disclosed.)

- ☐ Alcohol/Drug Abuse
- ☐ Psychiatric Care
- ☐ Hiv/Aids
- ☐ Sexually Transmitted Diseases, Testing and results **Initials**_____
- ☐ Communicable Diseases

I understand these facts about the release of information by Childcare Associates:

1. **Consent for release of information is not required as a condition of treatment.**
2. **This authorization may be revoked at any time except that the information that has been disclosed prior to the date of revocation.**
3. **Only information necessary to fulfill the purpose(s) stated above may be released.**
4. **I understand that if I authorize disclosure of protected health information, the recipient may further discloser this information and federal law will not protect it.**
5. **I understand that I have the right to inspect or copy the information I am consenting to release.**
6. **A copying fee will be applied of .65 a page.**
7. **Once this authorization has expired we will no longer use or disclose your health information.**
8. **I am entitled to receive a copy of this sign authorization. I have received a copy. Initial here:**_____
9. **I understand that information may be released by any acceptable means, including fax.**
10. **This authorization will expire in 6 months (180 days) from the date below or on:** _____
11. **A copy of this release is as an original (e.g. fax).**

Date: _____ _____ _____
Signature of patient/ authorized representative **relationship if not patient**
Witness: _____ **I.D. Checked (please initial):** _____

Interpreter's statement:
I have translated the information pf this form orally to the individual in _____ **(language) and explained its contents to him/her. To the best of my knowledge and believe she/he understood the explanation.**