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MEDICAL RECORDS RELEASE

Patient Name: _____ _____ _____
Last First Middle Initial

DOB: ____/____/____ Home Phone: _____-____-____ Other Phone: _____-_____-_____

Date Requested: _____ Date Needed: _____

Please Release Records:

Receipt Method:
__ Mail
__ Drop off
__ Fax/Email

From: **To**:

_____ _____
_____ Adress: _____
_____ City/State:_____
_____ Phone & Fax:_____

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

__Health summary and immunization record
__Information from the last 2 years of care
__All

For 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 **Initials**: _____
__HIV/AIDS ___Sexually Transmitted Diseases, Testing Results
__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 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 $0.65 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 6 (six) 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 to him/hr. To the best of my knowledge and believe she/he understood the explanation.