Authorization for Release of Medical Records

Robeson Pediatrics
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Patient Name:_____ **DOB:** _____

Address: _____ **Chart:** _____

_____ **SSN:** _____

☐ I hereby consent to and authorize Robeson Pediatrics to Release to:
☐ I hereby consent to and authorize Robeson Pediatrics to Receive from:

Facility/Individual Name **Phone Number**

Address **Fax Number**

City **State** **Zip**

Please send a copy of my records as indicated for date(s) of Treatment: _____

☐ All Records	☐ Labs	☐ Newborn Screen
☐ Discharge Summary	☐ Last Physical	☐ Problem List
☐ Immunization Record	☐ Medication List	☐ Radiology Reports
☐ Other: _____		

Purpose for releasing medical information: _____

This information may be communicated through written, oral, or electronic means. I understand that use of a fax machine to transmit information could result in loss of confidentiality of these records/medical information. I am willing to accept this risk.

All information released will be held strictly confidential consistent with the Robeson Pediatrics Policy and cannot be released without my written consent, except under very limited circumstances, understand that this release is valid for a period of 1 year and is subject to revocation at any time by me, except to the extend action has already begun in reliance on this authorization.

Any re-disclosure of this medical information by a recipient other than the patient's prior written consent is prohibited.

Signature of Patient/Legal Representative **Relationship to Patient** **Date**

Witness Signature **Date**