Crown Colony Pediatrics

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Authorization to Release Patient's Medical Records from Crown Colony Pediatrics

Patient's Name: _____ Date of Birth: _____/_____/_____

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

IF LEAVING THE PRACTICE PLEASE LET US KNOW THE REASON FOR LEAVING:

_____

IF REQUESTING COMPLETE RECORDS **PLEASE SIGN ALL THREE RELEASES BELOW:**

1. I HEREBY AUTHORIZE CROWN COLONY PEDIATRICS TO RELEASE FULL CONTENT OF MEDICAL RECORDS, INCLUDING ALL RECORDS RECEIVED FROM PRIOR PHYSICIANS TO

   PARENT/PATIENT'S NAME: _____

   SIGNATURE: _____ DATE: _____

2. THIS MEDICAL RECORD MAY CONTAIN INFORMATION ABOUT DRUG ABUSE, ALCOHOLISM, VENEREAL DISEASE, ABORTION, OR MENTAL HEALTH TREATMENT. SEPARATE CONSENT MUST BE GIVEN BEFORE THIS INFORMATION IS RELEASED.

   CIRCLE ONE: I DO I DO NOT CONSENT TO HAVE THIS INFORMATION DISCLOSED

   SIGNATURE _____ DATE: _____

3. THIS MEDICAL RECORD MAY CONTAIN INFORMATION CONCERNING HIV TESTING AND/OR AIDS DIAGNOSIS OR TREATMENT. SEPARATE CONCENT IS REQUIRED TO HAVE THIS INFORMAION TO BE RELEASED.

   CIRCLE ONE: I DO I DO NOT CONSENT TO HAVE THIS INFORMATION DISCLOSED

   SIGNATURE _____ DATE: _____

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