Crown Colony Pediatrics

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

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

Parent/Guardian Name: _____

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Phone: _____ ☐ Cell ☐ Home Email: _____

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

Patient/Parent/Guardian Signature _____ Date: _____

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

I CONSENT TO HAVE THIS INFORMATION DISCLOSED.

Patient/Parent/Guardian Signature _____ Date: _____

THIS MEDICAL RECORD MAY CONTAIN INFORMATION CONCERING HIV TESTING AND/OR AIDS DIAGNOSIS OR TREATMENT. SEPARATE CONSENT IS REQUIRED TO HAVE THIS INFORMATION RELEASED.

I CONSENT TO HAVE THIS INFORMATION DISCLOSED.

Patient/Parent/Guardian Signature _____ Date: _____

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