Universal Pediatrics, PC

Authorization to Release Medical Information

Date:_________________

I authorize: ___________________________ Address: __________________________

(Company Name) __________________________

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To release information from the medical record of: _____________________________

(Patient's Full Name)

Reason for Request:____

To: ___________________________ Address: _________________________

(Company Name) _________________________

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Attention To:____________________________

For the purpose of review/examination, I authorize you to provide the following information

☐ Complete Copy of Medical Record   Disclosure Log ☐

☐ Specific Information

I give specific permission to release any information related to:

_______Substance Abuse ______Psychiatric/mental health ______HIV/AIDS

This authorization will expire sixty (60) days from the date signed. I understand that I may revoke this authorization, in writing, at any time except to the extent that action has been taken in reliance thereon. I understand that if I am releasing this information to an entity or individual not covered by HIPAA, this information is no longer protected by HIPAA.

Patients or Legal Guardians Signature: _____________________________________ Relationship:___________

Witness:__________________________ Practice: __________________

Identifying Information:

Name at time of treatment, if other than above: _______________________ Date of Treatment: ____________

Date of Birth:_____________ SS#: ___________________________