



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name _____ Date of Birth

Address: Street Address City State Zip

I hereby authorize Birth & Beyond Pediatrics, P.C. to:

Release to (who/where):	Obtain From:
Name: _____	Name: _____
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____

Photocopies of my/my child's medical records and/or health information.

Requested Information:

- | | |
|---|--|
| <input type="checkbox"/> Entire Designated Record | <input type="checkbox"/> Billing records |
| <input type="checkbox"/> Patient Notes | <input type="checkbox"/> Shot records only |
| <input type="checkbox"/> Information created or received from other providers | <input type="checkbox"/> X-rays/reports |
| <input type="checkbox"/> Specify _____ | <input type="checkbox"/> Lab reports |
| <input type="checkbox"/> Other: _____ | |

For records released by Birth & Beyond Pediatrics, P.C., I agree to pay \$1 for the first page/ 50 cents per page thereafter for each copy or copies before such copies are released and I also agree to pay the actual cost of postage if the record is to be mailed.

I understand that this authorization will expire on ____/____/____ (MM/DD/YY) Initials _____

I understand that I may revoke this authorization at any time by notifying Birth & Beyond Pediatrics, P.C. in writing, but if I do, such revocation shall have no effect on any actions taken before receipt of my revocation. Initials _____

I further release Birth & Beyond Pediatrics, P.C. from the responsibility for any deleterious effect the release of my clinical medical records may have upon myself or others both now and in the future. I personally accept all responsibility for my own distribution and interpretation of medical information contained therein and hold blameless Birth & Beyond Pediatrics, P.C. for conclusions or opinions drawn from said records without professional knowledge, assistance, or review.

By State law, you must be advised that: **The information authorized for release may include records which may indicate the presence of a communicable or non communicable disease; or venereal diseases, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus also know as Acquired Immune Deficiency Syndrome (AIDS).**

I realize by the release and/or receipt of these records that I am accepting responsibility for the protection of my own right of medical record confidentiality.

Signature of Patient/Parent/Legal Guardian _____ Date

Relation to patient (if other than patient)