OLSON PEDIATRIC CLINIC

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT INFORMATION:

Last _____ First _____ Middle _____ Date of Birth _____

Street _____ City _____ State _____ Zip _____ Home Phone _____

RELEASE FROM:

Physician/Clinic Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

SEND TO:

Physician/Clinic Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

☐ **ALL MEDICAL RECORDS** _____

☐ **SPECIFIC Information only:**

History & Physical from _____ **to** _____

Medications _____

Lab, Path, Xray _____

Accident or Injury from _____ **to** _____

Immunizations _____

Other _____

SIGNATURE OF PATIENT/PARENT OR GUARDIAN_____

Date _____

I do/do not ☐ ☐ SPECIFICALLY CONSENT TO THE TRANSMISSION OF MEDICAL RECORDS VIA FACSIMILE (FAX) MACHINE WITH THE UNDERSTANDING THAT THE CONFIDENTIALITY AT THE RECEIVING END CANNOT ALWAYS BE GUARANTEED

Some types of information require A specific authorization to be released because of federal or state laws. They are identified below. By signing, I specifically authorize the release of the following confidential information. (Each individual item must be checked)

HIV test and test results and related information including high risk behavior documentation _____
Signature

Drug/Alcohol diagnosis, treatment, or referral information _____
Signature

Mental Health treatment information _____
Signature

Intended for the purpose of: _____

PRINT EMAIL