BIRTH & BEYOND
PEDIATRICS P.C.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: ____ /____ /____

Address: _____ City: _____ ST: _____ Zip: _____

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

RELEASE TO (WHO/WHERE):

Name: _____

Address: _____

City/State/Zip: _____

OBTAIN FROM:

Name:_____

Address: _____

City/State/Zip: _____

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

REQUESTED INFORMATION:

- ☐ Immunization Records
- ☐ Growth Chart
- ☐ Chronic illness(es): _____
- ☐ 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 ____ /____ /____

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)*