Primary Care Pediatrics
and Family Medicine

29869 Capshaw Road, Harvest, Al 35749

Authorization to Release or Obtain Medical Information

Patient Name: ____ DOB: ___/___/____
Last Name First Name Middle Name

I, ____hereby authorize the release of medical information

____To/ ____ From

Primary Care Pediatrics and Family Medicine, P.C.
29869 Capshaw road, Harvest, AL 35749

Doctor/Clinic/Hospital: ____
Address: ____
Telephone Number: ________________________Fax Number: __________________

Please release the following:
___ **All health information (including growth charts and vaccination records)**
___ History/Physical Exam
___ Progress Notes
___ Discharge Summary
___ Consultation Reports
____Diagnostic Test
____Radiological test or imaging test
____Lab report
____Pathological test
___Other (specify): ____

I also consent to the specific release of the following records:
_____Drug/Alcohol/Substance abuse
_____Tests for antibodies to HIV
____ Psychiatric/Mental Health
____ Diagnosis and Treatment Genetic Information

Purpose of disclosure: ___ Treatment/ Ongoing medical care ___ Coordination of care

REVOCATION: This authorization to release confidential information may be revoked by me, in writing, at any time, except to the extent that action has already been taken. Otherwise, this authorization shall remain valid for 1 year from the day on which it is signed. *I authorize transmission of my health records in situations where this information is needed for continuing care.*
A photocopy or facsimile of this authorization shall be considered as effective as valid as the original.
I have been advised of my right to receive a copy of this authorization.

Signature: _________________________________ Date: ____/____/____
Print Name: ________________________________Relationship to Patient: ____________
Witness Name: ______________________________Witness Signature: ____________

Please fax records to 877-384-6047 or mail them to the address above. If you have any questions, please call us at 256-262-1040