PROVIDENCE PEDIATRIC PRACTICE,LLC
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PLEASE DO NOT SEND DISK. PLEASE DO NOT FAX.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I,_____, authorize _____ to furnish to Providence Pediatric Practice all information included in my medical record (unless indicated otherwise below), to include, but not limited to: treatments, test results, reports, immunizations and to also include medical records which may contain information concerning treatment of any physical or mental conditions. Further, any test results or reports from specialists which may be in the medical record may also be released. In addition, I also authorize the release of psychiatric/psychotherapy, mental health and drug and alcohol treatment information.

Please indicate very specifically any information you wish to exclude from this release.
Please exclude_____
_____
_____

Patient Name:
DOB:

Signature_____ DATE:_____

Relationship to Patient_____

Witness:_____