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DO NOT SEND DISK. DO NOT FAX RECORDS.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I,_____, authorize Providence Pediatric Practice to furnish to_____or an authorized representative, all/ any information regarding treatments, test results, reports, 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. This office is not responsible for any dissemination or disclosure of your confidential medical information once we provide such information, AT YOUR REQUEST, to the above named person or facility.
Please indicate very specifically any information you wish to exclude from this release.
Please exclude_____
_____
_____

Patient Name:
DOB:

Signature_____ DATE:

Relationship to Patient_____

Witness:_____

Transferring to:_____

Address_____

_____

Reason for Transfer or Request:_____

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