Pediatric Associates of Madison

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
Each Patient Must Have a Separate Release Form

PLEASE PRINT CLEARLY **DATE:**_____

Patient Name: _____ Date of Birth: _____

Please Check One:
Send Records to □ **Obtain Records From** □

Person/ Organization:_____

Street Address: _____

City: _____ State:_____ Zip: _____

Phone No:_____ Fax No:_____

Information to be sent or received: (check all that apply)

_____Immunizations
_____Problem List
_____Growth Charts
_____Other /Specify: _____

Purpose of Disclosure:

_____ Leaving Practice _____Specialist Referral
_____ Personal Use _____ Insurance Purposes
_____ Relocating/Transfer

A $10 RETRIEVAL FEE AND A FEE OF .50 PER PAGE WILL BE CHARGED FOR ANY RECORDS THAT HAS TO BE RETRIEVED FROM STORAGE.

I hereby Release and Authorize Pediatric Associates of Madison, P.C. to Release the Medical Records of the dependent listed (or self 18 or over) including diagnosis, treatment, prognosis, and recommendation, as well as other data pertinent to patient's treatment to the following location listed above. I hereby state that I am the child's parent or court appointed legal guardian and have the legal right to make and/or restrict healthcare decisions regarding this child, and that my parental authority has not been terminated or restricted by the courts. I understand that is authorization will expire twelve months from the date signed.

_____ _____
Signature Date

Relationship to child: _____

NOTE: We ask that we be allowed 10 to 14 working days to process a release of medical information.