// # Westside Pediatric Clinic, P.C.

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Do not fax records if more than 20 pgs

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

This authorization must be written, dated, and signed by the patient or by person authorized by law to give authorization

Patient:____DOB:__________

Patient:____DOB:__________

Patient:____DOB:__________

Patient:____DOB:__________

I authorize ____________________	to release information to __________________
(name of provider)	(name of provider)
(address of provider)	(address of provider)
(city, state, zip)	(city, state, zip)

PURPOSE OF DISCLOSURE:____

By initialing the spaces below, I specifically authorized the release of the following medical records, if such records exist:

_____ Lab Reports	_____Most recent 5-year study	_____Pathology Reports
_____ Clinician office chart notes	_____Diagnostic Imaging Reports X-Ray	_____Billing Statements
_____ Entire Medical Records		_____Immunization Record Only

The recipients understands that this record may be voluminous and agrees to pay all reasonable charges associated with providing this record

SEPARATE & SIGNED AUTHORIZATION FORM IS REQUIRED FOR THE FOLLOWING:

* HIV/AIDS related records
* Genetic testing
* Mental health information
* Drug/Testing diagnosis, treatment, and Referral information

SIGNATURE:____________________________________ **Date:**__________

This authorization may be revoked at any time; the only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of the signing or shall remain in effect for the period reasonably needed to complete the request.