WESTSIDE PEDIATRIC CLINIC

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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.

Records can be securely emailed to: medicalrecords@westsidepediatrics.com

Patient: _____ DOB:_____

Patient: _____ DOB:_____

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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: _____

The recipient understands that this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.
Please note there is a $30.00 charge for any personal requests.

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

____ Entire Medical Record ____ Diagnostic Imaging ____ Lab/Pathology reports

____ Immunization records only ____Clinician office chart notes ____Other/Specify_____

Protected or Sensitive Information

I understand that certain information cannot be released without specific authorization as required by state/federal law. By initialing, I authorize the release of the following protected or sensitive information.

____ HIV/Aids Test Results ____ Drug Dx/Tx ____Genetic Testing ____ ADD/Mental Health Tx

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.