AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____
_____
(Print Patient's Full Name) (Birth Date: mm/dd/yyyy)

_____
_____
(Street Address) (Social Security Number)

_____
_____
(City, State, Zip Code) (Home Phone Number)

I _____(Parent/Patient if 18+ yrs old), do hereby authorize JOY & CROWN PEDIATRIC SPECIALISTS to release:

_____Progress notes _____ Pathology Reports_____ Other Doctor Notes
_____ All Records
_____ Lab Reports _____OB/GYN Notes _____ Radiology Reports
_____ Hospital Notes
_____ ECG/EEG/Cardio
Other:_____

I do / Do Not: Authorize release of information related to AIDS/HIV, or any other communicable diseases, psychiatric care, and/or psychological assessments, along with treatment for alcohol and/or drug abuse.

Information Release To:

_____

(Name: Physician, Hospital, Agency, Etc.)

_____

(Street Address)

_____

(City, State, Zip Code)

Purpose of disclosure: _____Referral to Specialist _____Insurance _____Worker's Comp _____ Legal Investigation _____ Disability _____ Personal _____Relocated _____ Other (specify):_____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification; however, this will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization. I understand that I may REVOKE this authorization at any time.

Reason for transferring:_____

Please provide a current phone number in case we need to contact you:_____

_____

Signature of Patient if 18+ yrs old

Date:_____

_____

Signature of Parent/Legal Guardian if Patient is a minor

Date:_____

If your child is over the age of 18 they must sign the release in order for JOY & CROWN PEDIATRIC SPECIALISTS to release their records.
NOTE: There will be an $25.00 charge for records.