Pediatric Health Care Associates, S.C.

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

*Name*_____ *Date of Birth* _____

I hereby authorize the below listed entity to release medical information to Pediatric Health Care Associates, S.C.

Name: _____*Telephone#:* _____*Fax:*_____

*Relationship:*_____ *Address:* _____

Medical Information Requested:
[ ] All Records

[ ] Specific Records from _____ *to* _____

[ ] Immunizations & Physical Examinations

*Signature of Patient or Legal Guardian*_____

Date: _____*Name of Parent/ Legal Guardian* _____

This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent.