Crown Colony Pediatrics

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

CHILD'S NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

_____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: _____

I HEREBY AUTHORIZE _____
TO RELEASE FULL CONTENT OF MEDICAL RECORDS, INCLUDING ALL TEST RESULTS AND RECORDS RECEIVED FROM PRIOR PHYSICIANS TO CROWN COLONY PEDIATRICS.

PARENTS SIGNATURE _____

THE MEDICAL RECORD MAY CONTAIN INFORMATION ABOUT DRUG ABUSE, ALCOHOLISM, VENERAL DISEASE, ABORTION, OR MENTAL HEALTH TREATMENT. SEPARATE CONSENT MUST BE GIVEN BEFORE THIS INFORMATION IS RELEASED.

I CONSENT TO HAVE THIS INFORMATION DISCLOSED.

PARENT SIGNATURE _____

THIS MEDAL RECORD MAY CONTAIN INFORMATION CONCERING HIV TESTING AND/OR AIDS DIAGNOSIS OR TREATMENT. SEPARATE CONSENT IS REQUIRED TO HAVE THIS INFORMATION RELEASED.

I CONSENT TO HAVE THIS INFORMATION DISCLOSED.

PARENTS SIGNATURE _____