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AUTHORIZATION FOR RELEASE OF MOTHER'S MEDICAL RECORDS

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.

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.

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.

SIGNATURE ____