stellar
PEDIATRIC URGENT CARE

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

I hereby authorize the release of my child's medical records and/or health information as specified below:

Releasing Provider/Office:_____Phone: (_____) _____-_____
Fax: (_____) _____-_____ Email:_____

Person(s) listed above is authorized to release ▫ photocopies OR ▫ digital files of my child's medical records and/or health information. Please DO NOT fax medical records over 25 pages. We will not fax records larger than 25 pages to another facility.

To the following named individual or organization:
_____
Address: _____ ▫ Pickup ▫ Mail ▫ Email
_____ Phone/Fax: (_____) _____-_____
Email: _____

This information will be obtained, used, or disclosed for the following purpose:
▫ Continued treatment ▫ Personal Use ▫ Transfer
▫ Other_____

Information to be released:
▫ Complete Record ▫ Immunization Record ▫ Records during: ___/____/____-___/____/___ ▫ Records concerning_____

I agree to pay $0.50 per page for paper records or $0.30 per page for records released in electronic format, plus the cost of postage, if applicable. I agree to pay prior to receiving my records, and understand that these charges apply for records that are requested and not picked up within a timely manner. Any requested records left unclaimed for 3 months will be discarded.

Fees may be waived if we are mailing records to another physician.

I further release Dr._____ from responsibility for any deleterious effect the release of my child's clinical medical records may have upon myself or others both now and in the future. I personally accept all responsibility for my own distribution and interpretation of medical information contained therein and I hold blameless the Office of Stellar PLLC, for conclusions or opinions drawn from said records without professional knowledge, assistance, or review.

By State Law, you must be advised that: the information authorized for release may include records which may indicate the presence of communicable or venereal diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus also known as Acquired Immune Deficiency Syndrome (AIDS).

I realize by release and/or receipt of these records that I am accepting responsibility for the protection of my own right of medical record confidentiality.

_____ _____

Signature of parent/patient/ guardian Date

Date Received_____ Date Released____/_____/_____