Bridgewater pediatrics
QUALITY MEDICINE · COMPASSIONATE CARE

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete this form thoroughly. Your medical record cannot be released until this form is completed, signed by the patient or legal guardian and returned to our office. There may be a processing fee associated with this request.

STEP 1: PATIENT INFORMATION

Contact #: _____

Patient Name: _____ Date of Birth: _____

Address: _____

STREET CITY STATE ZIP

STEP 2: WHO HAS YOUR RECORDS NOW?

Name/Address of Physician: _____

_____

_____

STEP 3: TO WHOM DO YOU WISH TO RELEASE YOUR RECORDS?

Name/Address of Physician: _____

_____

_____

STEP 4: WHICH RECORDS WOULD YOU LIKE RELEASED?

___ All Records, or

___ Dates of Service: _____ to _____

You must specifically check yes or no for each category below:

Y ___ N ___ Abortion	Y ___ N ___ Substance Abuse	Y ___ N ___ Anxiety/Depression
Y ___ N ___ AIDS	Y ___ N ___ Illegitimate Birth	Y ___ N ___ Eating Disorders
Y ___ N ___ HIV Testing	Y ___ N ___ Infertility Studies	Y ___ N ___ Sexual Assault/Rape
Y ___ N ___ Alcohol Abuse	Y ___ N ___ Mental Health Visits	Y ___ N ___ Sexually Transmitted Disease

STEP 5: SIGNATURE

I hereby authorize the release of the above information to the address indicated.

_____

PATIENT SIGNATURE DATE

_____

PARENT/GUARDIAN SIGNATURE DATE

*This authorization is valid for 90 days and may be revoked at any time in writing prior to the expiration date.
Please allow 10 business days for your records to be released.