Patient Release Form

To have your child's medical records released FROM Children's Medical Group to a new provider, complete form below.

Please allow 5-7 days for requested records to be sent.

PATIENT DETAILS

Name | SSN/Health Record # | Date of Birth

Address | City | State | Zip | Phone

PREVIOUS PROVIDER DETAILS

I authorize Children's Medical Group, P.A. to use or release my health information as described below.

Select office:

☐ **Airport Office**
3920 Airport Blvd | Mobile, AL 36608
(251) 342-3810

☐ **Providence Office**
610 Providence Park Dr | Mobile, AL 36695
251-639-1300

RECORDS TO RELEASE

Please identify the information to be released:

☐ **Please release my entire record** -OR-

☐ **Please release only the following information:** *(check appropriate boxes and include other information where indicated)*

☐ Problem List ☐ List of Allergies ☐ Immunizations ☐ Medication List

☐ Office Notes ☐ History & Physical ☐ Discharge ☐ ER

☐ Lab Results ☐ X-ray and Imaging Reports ☐ Consultation Reports ☐ Other *(please describe)*

The identified information will be used for the following purpose:

☐ **Change to another pediatrician** ☐ **Attorney/Legal** ☐ **Other** *(please specify)*

☐ **My personal records** ☐ **Continued care** *(consult/referral)*

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Patient Release Form

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Please initial each item below to indicate your understanding.

(Initial) I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

(Initial) I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

(Initial) I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

(Initial) I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

The identified information may be used by or released to the following individual(s) or organization(s):

Name | Phone | Fax

Address | City | State | Zip

This authorization will expire on _____ *(insert date or event)*: ***If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.***

Patient Signature / Parent / Legal Guardian | Relationship | Date (MM/DD/YYYY)

Witness Signature | Date (MM/DD/YYYY)