AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize Pediatrics at the Basin (Dr. Cranshaw, Dr. Strang, Dr. Loveys) to use and disclose a copy of the specific health information described below.

Patient(s):

Name _____ Date of Birth _____
_____ _____
_____ _____
_____ _____

To be disclosed to:
Name of Recipient(s)): _____
Address: _____
_____
Phone: _____ Fax: _____

Information to be released:

___ *Record summary only* (latest office visit and physical, immunizations, diagnoses, medications, growth charts)

___ *Any and all records* (includes ALL types of record listed below. Includes secondary release of records from other offices, hospitals, clinics, laboratories, radiology, mental health, HIV and genetic testing)

Only records types checked below:
__ History and physical. __ Immunization record. __ Allergy record.
__ Medication records. __ Laboratory reports. __ Emergency and urgent care records.
__ Mental health records. __ Consultations. __ Radiology reports. __ Pathology reports.
__ Operative reports. __ Rehab records (PT/OT/ST). __ Genetic testing.
__ Chemical dependency/substance abuse records. __ HIV records
__ Other records (specify record type(s):

OPTIONAL LIMITS – Disclose only records related to the following:
Date(s) of service: _____ Injury or illness: _____

Purpose: _____

Unless revoked, this authorization expires in 180 days or on this date: _____

Patient Signature _____ Date _____

Parent/representative signature _____

Rep. name/relationship _____ Date _____