AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

Provider Name: (released from)	☐ Other: ☐ Complete Pediatrics (circle): Michelle Caserta, MD / Liesel Gould, MD / Linda Jacobson, CPNP, APRN / John Ramirez, MD / Margaret Shea, APRN
Patient/Client Name:	
Patient Date of Birth:	

I, _____, hereby authorize the above-named provider to release my (son/daughter's) medical/academic records, including a copy of my complete and entire mental health record, all records for my (son/daughter's) care and treatment, including psychiatric and drug information, and information regarding my HIV/AIDS status, treatment or testing, emergency room records, nursing notes, laboratory results, pathology reports, x-ray reports, films, all consent forms, and a copy of the bill for services rendered, to:

(released to)

- ☐ Other:
- ☐ Complete Pediatrics (circle): Michelle Caserta, MD / Liesel Gould, MD / Linda Jacobson, CPNP, APRN / John Ramirez, MD / Margaret Shea, APRN

If any of the information to be released constitutes a psychiatric communication or a communication with a psychologist, or any other mental health worker, this release will serve as my written release of that information. I understand that I may refuse to grant the consent for this release of mental health information, and such a refusal will in no way jeopardize my right to continue to obtain treatment, unless disclosure is otherwise permitted by law or necessary for treatment. I understand that no psychotherapy notes may be disclosed by my signing this authorization, and that a separate authorization would be required for the release of psychotherapy notes.

If any of the information to be released relates to treatment for alcohol and drug abuse, I understand that there are special requirements for my consent to release as found in Part 2 of Title 42 of the Code of Federal Regulations (CFR), which prohibits the further release of that information without my consent, as referenced in the federal regulations, or as otherwise permitted by law.

The information to be used/disclosed consists of:

- ☒ Front sheet & problem list from EMR, immunizations, correspondence from sub-specialists, growth/BMI charts & last year of chart notes (paper medical record only), last 3 years of physicals and preprinted blue school form from CIRTS if available.

If patient is requesting records in addition to or different than as listed above, check the following box and provide a description of the records requested.

- ☐ Vanderbilt scales, school performance, other academic or psycho-educational testing
- ☐ Other:
- ☐ Entire chart

Note: This description must be specific and meaningful.

The information will be used/disclosed for the following purposes:

- ☐ To aid with medical management
- ☐ To transfer medical care
- ☐ Other:

This authorization is valid unless and until it is revoked, in writing, and properly presented to the records office of the provider listed above.

I understand that if the person or the entity that receives the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization. I understand that I may revoke this authorization in writing at any time by submitting a written notice of my revocation, except to the extent that action has been taken in reliance on this authorization.

The authorization expires _____.

_____ _____

Signature of Patient/Client, or his/her authorized representative, parent or guardian if a minor. Please specify relationship to patient/client.

Date

If a representative signs, describe the representative's authority to act on behalf of the patient: