Children's Garden Pediatrics

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Authorization for Release of Medical Records

Patient Name: _____ DOB: _____

Patient Address: _____

_____

_____

I authorize the following entity to release to **Children's Garden Pediatrics, LLC** a complete copy of my child's medical record (or, if applicable and approved by the patient, a summary of the medical record), for the purpose of continuing medical care:

Physician/Practice: _____

Address: _____

_____

_____

The following categories of information will not be released unless I indicate my authorization by initialing next to the corresponding category(ies):

Adoption	_____	Genetic Test Reults	_____
Mental Health	_____	Termination of Pregnancy	_____
Drug Treatment	_____	Sexually Transmitted Disease	_____
Alcohol Treatment	_____	HIV Test/ Treatment Records	_____

This authorization shall remain in effect until 90 days after the date below unless I request, in writing, a revocation of this authorization.

Signature: _____ Date: _____
Parent or Legal Guardian (Patient if over 18)

Print Name: _____