



Canadian Valley Pediatrics

Dr. Dina Bowen 1804 Commons Circle Suite B Yukon, OK 73099

Email: [medicalrecords@shgcvp.com](mailto:medicalrecords@shgcvp.com) Phone: (405) 577-6700

Fax: (405) 265- 4135

**AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby authorize the release of my child's medical records to Canadian Valley Pediatrics from:

DOCTOR: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

**PLEASE INCLUDE VACCINE RECORD**

For the purpose of:  Continuing or transfer care  Vaccine record  Legal matters

\_\_\_\_\_ Release information concerning the following dates: from \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_ Complete medical record

\_\_\_\_\_ Other (specify): \_\_\_\_\_

I  DO or  DO NOT (check one & initial here \_\_\_\_\_) consent to the release of information relating to psychiatric or psychological testing or treatment, alcohol and/or drug abuse diagnosis/treatment, or HIV (AIDS) testing.

I, the parent/guardian, agree that a photocopy or fax of this authorization may be considered valid, this authorization shall be valid for 100 days from the date of signature, and that this authorization can be revoked in writing at any time prior to the expiration date. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected.

Relationship to Patient (circle one): *self* *mother* *father* *guardian*

Parent/Guardian Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_