Canadian Valley Pediatrics

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(Do ***NOT*** fax medical records)

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Patient's name: _____ Date of birth: _____

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I hereby authorize the release of my child's medical records from:

_____

Name of Medical Practice, Physician, Clinic, or Hospital

Address _____

City, State, Zip_____

Phone number: _____ Fax number: _____

For the purpose of: (__) Continuing or transfer care. (__) Proof of immunization. (__) Legal matters

Release information concerning the following dates: from _____ to _____

Also, 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 120 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. I hereby release and hold harmless Canadian Valley Pediatrics, Dina M. Bowen, MD, PLLC from all liability and damage resulting from the lawful release of my Medical Records.

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

Parent/Guardian Printed Name _____Signature: X _____