



AUTHORIZATION FOR RELEASE OF INFORMATION

Release records TO:

Release records FROM:
Hometown Pediatrics of Joplin
200 Castle Drive
Joplin, MO 64804

Parent/Legal Guardian Name (Print): _____

I authorize you to furnish a copy of medical records for the below named child/children to the above-named doctor/medical facility. I release you from all legal responsibility or liability that may derive from this authorization. I also understand that I may revoke this authorization at any time, in writing, to the address listed above provided the information has not already been released. This Authorization for Release shall cease to be effective 30 days from this date.

_____ Patient's Name (Print)	_____ Date of Birth	_____ From	_____ To
_____ Patient's Name (Print)	_____ Date of Birth	_____ From	_____ To
_____ Patient's Name (Print)	_____ Date of Birth	_____ From	_____ To
_____ Patient's Name (Print)	_____ Date of Birth	_____ From	_____ To

Reason for Record Release or Copy: () Personal copy **<charges may apply>** () Over age 18 () Insurance change
() Moving/changing providers () Referral
() Other (Please Specify): _____

AREAS OF SPECIFIC INTEREST OR CONCERN

X Problem List / X Medication List / X Vaccines / X Lab Studies / X Consultations
 X Growth Charts / X Flow Charts / X Other: _____

Information to be Excluded / Not Released: () Mental Health Records () Drug/Alcohol treatment () HIV Testing
() Sexual Assault/Victimization Records () Other _____

Signature: _____ Date: _____
Parent/Legal Guardian