Hometown PEDIATRICS

AUTHORIZATION FOR RELEASE OF INFORMATION – PLEASE FAX THE RECORDS

[X] Release records TO:

Hometown Pediatrics of Joplin
200 Castle Drive
Joplin, MO 64804
417-626-0600 FAX

[ ] Release records FROM:

_____
_____
_____

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