Children's Medical Group, PLLC
Medical Record Release Form

By signing this authorization, I authorize Children's Medical Group to release and disclose protected health information about me to:

_____

Name of Entity to release information

_____ _____

Phone Number Fax Number

_____

Address

_____

City/State/Zip

This authorization permits Children's Medical Group to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, types of services, level of detail to be released, origin of information, etc.)

_____

_____

This information is necessary for the following purpose:

___ Continued Patient Care ___ Insurance ___ Other (specify) _____

___ Personal Use ___ Attorney/Legal _____

I understand that the information in my child's health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

There is a $25.00 minimum fee that applies per patient if you are requesting/transferring medical records from CMG

_____ _____

Patient Name Patient DOB

_____ _____

Signature of Patient or Legal Guardian Relationship to Patient

_____ _____

Print Name of Patient or Legal Guardian Date

_____

Email address used/to be used for patient portal access

Patient/Guardian to be provided with a signed copy of authorization

Office Use: Date Completed _____ Initials _____

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