Timber Lane Pediatrics

primarycare

Authorization to Release or Obtain Medical Records

Patient Name _____ Date of Birth _____

Address _____ City/State/Zip _____

Phone _____

A) I hereby authorize records from:

Name_____

Address _____

City/State/Zip_____

Phone #_____Fax #_____

B) To be released to:

Name_____

Address_____

City/State/Zip_____

Phone # _____ Fax # _____

C) For the purpose of:

_____ Transfer of care in/out of practice
_____ Disability/SSI
_____ Insurance
_____ School / Camp
_____ Other (please specify)_____

D) Information requested:

Date Range_____ to_____

_____Minimum Necessary
_____All Medical Records (includes outside records)
_____Immunizations Only
_____Last Physical Only

By signing this release I/we understand that:

- Some record requests may be subject to a copying fee (.50/page or $20 per disc), to be disclosed at the time of signing. Medical records will be disclosed in paper and/or CD form
- Unless otherwise revoked, this authorization will expire 1 year from the signed consent.
- I understand that I am authorizing the disclosure of medical records to be released to the above practice/person(s)

_____ _____

Parent, Guardian, Legal Representative Signature Date

_____ _____

Patient (18 years and older) Signature Date