Authorization for Release of Medical Information

Patient Name:_____ DOB:_____

I, _____, hereby authorize the release of medical information:

Disclosure To:	**Disclosure From:**
Phillips Pediatrics, LLC **2682 W. Oxford Loop, Ste. 130** **Oxford, MS 38655** **Office 662.371.1543** **Fax 662.371.1548**	Name of Provider/Organization/Facility:
	Address:
	City/State/Zip
	Phone/Fax:

The purpose or need for this disclosure is:

☐ Treatment/Continuing Medical Care

Please release the following:

☐ **All health information (including growth charts and vaccination records)**

☐ Summary of care (including growth charts and vaccination records)

☐ History/Physical Exam ☐ Diagnostic Test Reports ☐ Progress Notes

☐ Radiology/Images ☐ Discharge Summary ☐ Lab Results

☐ Consultation Reports ☐ Pathology Reports

☐ Other (specify):_____

I consent to the release of information related to HIV/AIDS or infection with any other communicable diseases, and information related to behavioral or mental health services (other than Psychotherapy Notes) and treatment for alcohol and drug abuse, with the rest of the medical records.

☐ Yes, I consent to the release of this information.

☐ No, I do not consent to the release of this information.

I understand that I may revoke this authorization in writing submitted at any time to the organization. Unless revoked sooner, this authorization shall expire:

☐ In 21 years from date of signature

☐ Expire on (Specify Date):_____

Signature:_____ Date:_____

Print Name:_____

Relationship to Patient:_____

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