Healthcare South, P.C.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete thoroughly. Your medical records cannot be released until this form is completely signed by the patient or legal guardian and returned. There may be a processing fee associated with this request.

PLEASE PRINT!!!

Patient Name: _____ (Last / First / MI)

Date of Birth ___ ___/___ ___/___ ___

Address: _____ (Street / City / State / Zip)

Telephone: _____ Fax: _____

I hereby authorize _____ M.D./D.M.D. to release my records.

Physician's Address: _____ (Street / City / State / Zip)

Telephone: _____ Fax: _____

Please release the following information for the purpose of (i.e. - transfer of care, special consultation, etc.)

_____ ☐ All Records or ☐ Dates of Treatment

Send To _____

Signature Required

This authorization is valid for 90 days and may be revoked at any time in writing prior to the expiration date. Additional authorization for redisclosure beyond recipient is required.

_____ _____
Patient's Signature Date

_____ _____
Witness Signature Parent/Guardian's Signature (If Patient is a minor)

Release For Sensitive Information – Signature Required

I UNDERSTAND THAT IF MY MEDICAL RECORD CONTAINS INFORMATION IN REFERENCE TO DRUG AND/OR ALCOHOL ABUSE, PSYCHIATRIC, VENEREAL DISEASE, SOCIAL SERVICE, HEPATITIS B TESTING/TREATMENT, AND/OR SENSITIVE INFORMATION, I AGREE TO ITS RELEASE.

_____ _____
Signature of Patient or Legal Guardian Date

Release of HIV Information – Signature Required

IN ADDITION TO THE ABOVE SIGNATURES, IF YOU WANT YOUR HIV (AIDS) TESTING/TREATMENT RECORDS RELEASED YOU MUST SIGN AND DATE ON THE LINE BELOW.

I AGREE TO THE RELEASE OF THIS INFORMATION.

_____ _____
Signature of Patient or Legal Guardian Date

Practice Locations:

Pediatrics

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