AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize KidMed to **(circle one)** obtain/transfer information on:

___________________________________ ___________________________
(Name of Patient) (Date of Birth)

OBTAIN FROM/TRANSFER TO: FAX TO:

____
(Physician/Institution)

_________________________________ _____________________________
(Address) (City, State and Zip Code)

____
(Phone)

☐ Send information electronically, Email Address:

____

☐ I understand that if information is not sent in an encrypted manner, there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.

For the purpose of:

____

Date(s) of Treatment: ____

Please Check Specific Information Requested

_______All Records
_______Discharge Summary
_______History & Physical
_______Pathology
_______Medication Records
_______Laboratory Reports
_______X-ray Reports
_______Emergency Room Report
_______Nurses Notes
_______Progress Notes
_______Operative Report
_______Operative Notes
_______Other

Other (Please Specify) ____

I understand that my records may contain but is not limited to: history, diagnosis, and/or treatment of HIV (AIDs virus), other sexually transmitted diseases, and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. This request is a free and voluntary act by me. I understand that I may revoke this authorization at any time to the extent that prior action has not been taken on this authorization. I also understand that my revocation of this authorization must be in writing. I understand that if the organization is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Authorization is valid for 90 days from the date of signature unless revoked in writing.
I have read and understand this consent and I have signed it voluntary.

____ __________________________ _________________
(Signature of patient or Parent/Legal Guardian) (Relationship to Patient) (Date)

____ ________________
(Witness) (Date)

*Description of Personal Representative if Applicable (attach necessary documentation)

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