Medical Records Release Form

Gvozden Pediatrics, PA

By signing this form, I authorize you to release confidential health information by releasing a copy of medical records, or a summary or narrative of protected health information, to the physician/person/facility/entity listed below.

Patient Name(s): _____ Date of Birth: _____

_____ Date of Birth: _____

_____ Date of Birth: _____

_____ Date of Birth: _____

The information you may release subject to this signed release form is as follows:

- ☐ Complete Records
- ☐ Record Summary
- ☐ Hospital Reports
- ☐ History & Physical
- ☐ Lab Reports
- ☐ Medication Record
- ☐ Progress Notes
- ☐ Radiology Reports
- ☐ Operative Reports
- ☐ Mental Health Notes

Release protected health information to the following physician/person/facility/entity and/or those directly associated in patient's medical care:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

The purpose/reason for this release of information is as follows:

_____

_____

_____

_____ _____

Printed Name of Patient, Parent or Personal Representative Relationship to Patient(s)

_____

Signature of Patient, Parent or Personal Representative

_____

Date