AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize KidMed to transfer, release or obtain information on:

_______________________________________ _________________________

(Name of Patient) (Date of Birth)

OBTAIN FROM: SEND OR FAX TO:

____ ____

(Physician/Institution) (Physician/Institution)

____ ____

(Address) (Address)

____ ____

(City, State, Zip) (City, State, Zip)

____ ____

(Phone) (Fax) (Phone) (Fax)

For the purpose of: ____

Date(s) of Treatment: ____

Please Check Specific Information Requested

_________All Records	_________Laboratory Reports	_________Operative Report
_________Discharge Summary	_________X-ray Reports	_________Operative Notes
_________History & Physical	_________Emergency Room Report	_________Other
_________Pathology	_________Nurses Notes	
_________Medication Records	_________Progress Notes	

____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. I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result to such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.

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)

Creation Date 4/15/2018
WE/ Admin/HR/ HIPAA