AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

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Patient Name:_____ Date of Birth:_____

I hereby authorize Dr. Wilson to release photocopies of my child's medical records and/or health information.

To the following named individual or Organization: _____
Address: _____
_____
Relationship: _____

Purpose:
_____ Insurance/Billing
_____ Other, specify: _____
_____ Transfer of care
_____ Copy of complete record
_____ Immunization record

I further release Dr. Wilson from the responsibility for any deleterious effect of the release of my child's clinical medical records may have upon myself or others both now and in the future. I personally accept all responsibility for my own distribution and interpretation of medical information contained therein and I hold blameless the office of Dr. Wilson for conclusions or opinions drawn from said records without professional knowledge, assistance, or review.

By State law, you must be advised that: The information authorized for release may include records which may indicate the presence of communicable or venereal diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus also known as Acquired Immune Deficiency Syndrome (AIDS).

I realize by the release and/or receipt of these records that I am accepting responsibility for the protection of my own right of medical record confidentiality.

_____ _____
Signature of parent, patient, or legal guardian Date

_____
Printed name of parent, patient, or legal guardian

Forwarding address: _____
_____
_____

FOR OFFICE USE ONLY, DO NOT WRITE BELOW

APM _____ Initials of releasing records _____
Date records released_____