WHOLE CHILD Pediatrics

WHOLE FAMILY Integrative Health

Medical Records Release Form

By signing this form, I authorize Whole Child Pediatrics/Whole Family Integrative Health to release my or my child's confidential health information. A copy of the medical record (s), or a summary or narrative of my protected health information may be released to the physician/person/facility/entity listed below.

Patient Name: _____ Date of Birth: _____
Information you may release subject to this signed release form is as follows:

[ ] Complete Records	[ ] History & Physicals	[ ] Progress Notes
[ ] Plan of Care	[ ] Lab Reports	[ ] Radiology Reports
[ ] Pathology Reports	[ ] Treatment Record	[ ] Operative Reports
[ ] Hospital Reports	[ ] Medication Record	[ ] other (please specify)
[ ] Vaccine Records		

I understand that I must check one or more of the following types of health information that I do **not** want released. I understand that if I do not check any of the three following items, the health information released may include the following:

[ ] Diagnosis, evaluation and/or treatment for alcohol and/or drug abuse
[ ] Records of HTL V-III or HIV testing (AIDS test) result, diagnosis and/or treatment
[ ] Psychiatric, psychological records or evaluation and/or treatment for mental, physical and/or emotional illness including narrative summary, test, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans and/or evaluation.

Release my protected health information to the following
Physician/person/facility/entity/and/or those directly associated in my medical care:

Name: _____ Phone: _____ Fax:_____

Address: _____

City: State: Zip Code: _____

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

_____ _____
Patient or Guardian Signature Date

I understand I have the right to revoke/withdrawal this authorization at any time as long as it is in writing to the medical record contact person at this site except to the extent the action has already been taken to release the information. Authorization is valid unless revoked but will expire in one year after signing.

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Our offices charge a $25.00 per person fee to release records.