COLUMBIA
Pediatrics
931-388-8965 Phone
931-388-0815 Fax

Authorization for the Release of Medical Information

Patient Name: **Birthdate:**

I_____ hereby authorize _____
to release and/or discuss the following information:

Complete Record	Outpatient Care	Inpatient Care	Immunizations
X-Ray Results	Laboratory Results	Treatment Plan	Other: _____

If the record contains the following information, I do not wish for the CHECKED items to be released:

□ Substance Abuse □ Mental Health Treatment □ AIDS/HIV □ Other_____

TO: Name _____

Address _____

Phone _____

Fax _____

I have carefully read and understand the above information, and do consent to the disclosure. I am aware that information regarding my medical condition will be released to those persons or agencies named above. I understand that, if the persons or agencies listed above are not subject to federal and state health information privacy laws, subsequent disclosure by such persons or agencies may not be protected by those laws. I understand that this consent is subject to revocation, in writing, at any time, unless action on it has already begun.

This authorization expires _____1 Time Release _____6 Months _____1 Year from today.

I authorize the use of copy of this form for the disclosure of the information described above.

Printed Name _____ Signature _____

Relationship _____ Date ____/_____/_____