Bright Future PEDIATRICS

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Authorization for Release of Medical Information

Patient Name: _____ DOB: _____ Date:_____

- ○ Please fax or mail my records to the Physician/Facility listed below
- ◉ I authorize BFP to obtain information from provider listed below
- ○ I will pick up copies of my records (additional fees may apply)

Name of Doctor/Facility: _____

Address: _____

City:_____ State: _____ Zip code: _____

Phone:

Fax:

Purpose for this request: (check one) Specialists ☐ Transfer of Care ☐ Personal ☐ Other ☐

Requested Information:

- ☐ Entire Medical Record
- ☐ X-Ray/Radiology Reports
- ☐ Lab/Pathology Reports
- ☐ Immunization Records
- ☐ Billing Records
- ☐ Most recent Progress Notes
- ☐ Mental Health Records (ADD/ADHD)
- ☐ Other _____

I hereby request access to the protected health information in my health record. I understand:

- I may revoke this authorization at any time by providing my written revocation to the address at the top of this form. My revocation will not apply to information already retained, used or disclosed in response to this authorization. Unless sooner revoked, the automatic expiration date of this authorization will be twelve (12) months from the date of signature.
- The information authorized for release may include records that may indicate the presence of a communicable disease or non-communicable disease and/or may indicate that I have been treated for a psychological or psychiatric condition(s).
- I understand there may be a charge for the requested records and will pay all fees for said records, starting at $1.00 for the first page and .50¢ for each additional page plus mailing costs. There will be charge for records sent to another physician and no charge for updated immunization records given at the time of vaccine administration.

Signature of Parent/Legal Guardian _____ Date _____

Relationship to Patient: _____