RIVERSIDE PEDIATRICS

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ give permission for the office of:

_____

_____

_____

To release my child(ren)'s complete medical records to:

Riverside Pediatrics

435 Marina Drive

Georgetown, SC 29440

843.833.8595 (phone)/843.833.8599 (fax)

Medical Records may include notes by providers or other personnel, results, reports, correspondence, x-rays or other imaging films, billing claims, payment information, HIV testing or treatment for AIDS or related conditions, drug or alcohol abuse, drug or alcoholism related conditions, psychiatric/psychological conditions unless specifically excluded. Please list exclusions below.

_____

Reason for release:

☐ Transfer

☐ Moved in/out of geographic area

☐ Health insurance change

☐ Age of child

☐ Referral

Information to release:

☐ Entire Medical Record

☐ Records for date range _____

☐ Records related to _____

☐ Other _____

Child(ren)'s names and birth dates:

_____ _____

_____ _____

_____ _____

Parent/Guardian Name, Address, and Phone Number:

_____

_____

_____

_____ _____

Signature of Parent/Guardian *Date*

- Only requested information will be sent. Information is kept confidential and used for medical reference only.
- This authorization will expire 180 days from when signed.
- Each patient may revoke this authorization at any time by notifying Riverside Pediatrics in writing. Revocation does not affect any actions taken by Riverside Pediatrics before receiving revocation.

_____ _____

Riverside Pediatrics Authorization *Date*