Lockman & Lubell Pediatric Associates, LLC

Record Release Form

Patient's Name: _____

DOB: _____

Address: _____

_____

Phone Number: _____

THE UNDERSIGNED AUTHORIZES THE RELEASE OF MEDICAL RECORDS TO:

Name: _____

Address: _____

_____

For the Purpose of: _____

Type of Information Requested:

_____

I authorize the above named source to release or disclose the following information: Any medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my condition(s), including psychological or psychiatric condition(s), alcohol and/or drug abuse, or any HIV-related information; (in accordance with Federal confidentiality rules (42 CFR Part 2), State Mental Health Procedures Act and ACT 148).

If there are any limitations to this list of information, please specify:

I understand this consent can be revoked at any time except to the extent that disclosure has already occurred in reliance on this request. Otherwise this authorization shall remain in effect for the period of 90 days from the date of my signature.

_____ _____

Signature of Patient/ Legal Guardian/ Legal Representative Date

Relationship to Patient _____

There is a $35.00 fee for record releases.