CLAYTON
PEDIATRIC CENTER

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: ____/____/_____
Address: _____ Phone: _____
_____
Parent/Legal Guardian Name: _____

Information to be Released BY	**Information to be Released TO**
◯ Clayton Pediatric Center ◉ Other Facility (if selected, complete below)	◉ Clayton Pediatric Center ◯ Other Facility (if selected, complete below)
Provider Name: _____ Address: _____ Phone: _____ Fax: _____	Provider Name: _____ Address: _____ Phone: _____ Fax: _____

Type of information to be released (check all that apply):

☐ Complete Medical Record ☐ Last Physical ☐ Immunizations
☐ Records from ____/____/_____ to ____/____/_____
☐ Records pertaining to: _____

Purpose of the disclosure:

◯ Transfer of Care ◯ Referral ◯ Personal ◯ Daycare/School
◯ Other: _____

I understand that my health records may contain sensitive information, including details about sexually transmitted diseases, AIDS or HIV, mental health, alcohol and drug treatments, and other sensitive information.

I acknowledge that information shared as per this authorization may be subject to re-disclosure by the recipient and might not be protected by federal or state privacy laws thereafter. I have the right to withdraw my consent at any moment by submitting a written revocation to Clayton Pediatric Center, though this will not affect any prior actions taken based on this consent. This authorization will continue to be valid only for as long as reasonably necessary to carry out the purposes enumerated above otherwise it will automatically expire ninety (90) days of the date signed. I recognize that providing this authorization is entirely voluntary and is not a condition for receiving healthcare or treatment.

I give my consent for the aforementioned entities to release and receive my medical information. I realize this information is private and can only be shared with my clear consent. By signing below, I confirm that I have read, understood, and agree to the terms of this authorization.

Signature: _____ Relationship to Patient: _____ Date: ____/____/____