Authorization For Release Of Medical Records
From PedEmerge

I have read and understand the following: I hereby authorize PedEmerge to release medical record(s) of the patient(s) below. I understand that the information is confidential and protected from disclosure. There is no charge if your pediatrician requests a copy of the last office encounter for their records. However, if the entire record is requested, the following copying fee applies: $10 for the first 15 pages and 50 cents for each additional page not to exceed $100. Records can be picked up in person or can be mailed (postage fee applies).

This authorization to release medical information may be revoked by myself, in writing at anytime, sent by fax or mail to PedEmerge except to the extent that this information has already been released.

Patient's Name: **Date of Birth:**

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Description of the information to be disclosed (Check one):

[ ] Last sick encounter (specify date)________________________

[ ] The patient's entire medical record (including psychiatric, drug/alcohol abuse, HIV information)

PLEASE FILL OUT FRONT AND BACK COMPLETELY

Who will receive these medical records? (Name and Address)

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Reason for release of Medical Records?

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I understand that this information may be re-disclosed by the receiving party, if they are not required by law to protect the privacy of the information

____ ______________
Signature of Patient or Parent/Legal Guardian **Date**

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Printed name of Patient or Parent/Legal Guardian

If not patient or Parent, nature of relationship to patient: ______________________

Name, address and phone number of the person making this request: (PLEASE PRINT LEGIBLY)

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FOR OFFICE USE ONLY (Do not write below this line)

Authorization witnessed by_______________________________________

Authorization added to patient's medical record on________________