

Authorization for Release of Medical Information

Patient Name: _____

DOB: ____/____/____

I, _____ hereby authorize the release of medical information **TO:**

**Puddle Dock Pediatrics
200 Griffin Road, Suite 12A
Portsmouth, NH 03801
603.457.7040 (office) 603.550.5244 (fax)**

FROM:

Doctor/Clinic/Hospital: _____

Address: _____

Telephone: _____ Fax : _____

Please release the following:

All health information (including growth charts and vaccination records)

History/Physical Exam Diagnostic Test Reports

Progress Notes Radiology/Images

Discharge Summary Lab Results

Consultation Reports Pathology Reports

Other (specify): _____

I consent to the release of information related to HIV/AIDS or infection with any other communicable diseases and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records

Yes, I consent to the release of this information.

No, I do not consent to the release of this information.

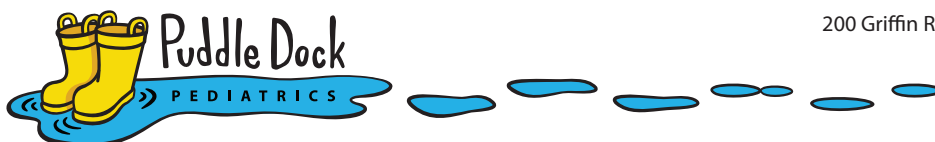
Purpose of disclosure:

Treatment/ Continuing medical care

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Signature of Parent or Legal Guardian: _____ Date: ____/____/____

Print Name: _____ Relationship to Patient: _____



200 Griffin Road, Suite 12A, Portsmouth, NH 03801
www.puddledockpediatrics.com
p. (603) 457-7040
f. (603) 550-5244