Hometown PEDIATRIC CARE

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Release of Records

Patient Name _____ DOB _____

Patient Name _____ DOB _____

Patient Name _____ DOB _____

Patient Name _____ DOB _____

Requesting from OR Sending to (please circle one)

Doctor/Facility_____

Address _____

Phone (_____)_____ Fax (_____)_____

Please release the following information:

_____ Complete Record or Records from _____ to _____

_____ Immunization Record

_____ Lab Results

_____ Other

By signing this form, I authorize you to release confidential health information about my child, by releasing a copy of his/her medical records, or a summary or narrative of his/her protected health information, to the person(s) or facility listed above for the purposes of continuation of care.

Parent Signature _____ Date _____