Kids'n Teens
CLINICS

Medical Records Request Form

Patient Name_____ Date of Birth_____

Guardian Name _____Relation _____

Phone#1 _____ Phone #2_____

Address _____City/State/Zip _____

I hereby authorize records FROM:

Name_____

Address_____

Phone#_____

Fax #_____

To be released TO:

Name_____

Address_____

Phone#_____

Fax #_____

Reason for request:

Legal Purposes Billing or Claims

Personal use $25 Disability Determination

School Insurance

Continuity of Care Transfer of Care

Other_____

Date Range _____to _____

- **Physician Office Notes**
- **ED/ Hospital Discharge Notes**
- **Immunizations/ LABWORK**
- **XRAY/ MRI/ ECG/ EEG results**
- **_____**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

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_____ _____

Date Signature of Patient/Parent/Guardian or Authorized representative

_____ _____

Date Witness