



CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Client Name _____ Date of Birth: ___/___/___

Client Address: _____

City/ State / Zip Code: _____

I _____ authorize Pediatric Associates of Michiana to release / obtain medical information from:

The following information from the above client's medical records is to be released:

- History & Physical X-Ray reports Psychiatric Info Progress Notes
 Lab reports Drug or Alcohol Info Consultation HIV
 Other (specify) _____

Dates of information/ visits/ testing to be released: From ___/___/___ to ___/___/___

The purpose of/need for disclosure is:

- Life/Health Insurance Application Employment Transferring Care
 Workman's Comp. Claim Lab reports Drug or Alcohol Info
 Other (specify): _____

I understand I may revoke this authorization at any time except in the case that the medical record has already been sent from the facility.

This authorization is automatically void sixty (60) days from the date of signature below. I also understand that this release may include medical records of treatment for communicable disease; physical and/or emotional illness, including treatment of alcohol or drug abuse; and HIV AIDS or AIDS related information, if marked for release.

Signature _____ Date _____
(Signature of patient/guardian/personal representative)

