

# Pediatric Associates of Madison

21 HUGHES RD. SUITE 2 MADISON, AL 35758  
(256)772-2037 FAX (256) 772-9523

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Each Patient Must Have a Separate Release Form

**PLEASE PRINT CLEARLY**

**DATE:** \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Please Check One:**

**Send Records to**  **Obtain Records From**

Person/ Organization: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone No: \_\_\_\_\_ Fax No: \_\_\_\_\_

**Information to be sent or received:**

- Immunizations, Problem List and Growth Chart
- Last 2 years of medical records

Other /Specify: \_\_\_\_\_

Purpose of Disclosure:

\_\_\_\_\_ Leaving Practice                      \_\_\_\_\_ Specialist Referral  
\_\_\_\_\_ Personal Use                              \_\_\_\_\_ Insurance Purposes  
\_\_\_\_\_ Relocating/Transfer

**A \$10 RETRIEVAL FEE AND A FEE OF .50 PER PAGE WILL BE CHARGED FOR ANY RECORDS THAT HAS TO BE RETRIEVED FROM STORAGE.**

I hereby Release and Authorize Pediatric Associates of Madison, P.C. to Release the Medical Records of the dependent listed (or self 18 or over) including diagnosis, treatment, prognosis, and recommendation, as well as other data pertinent to patient's treatment to the following location listed above. I hereby state that I am the child's parent or court appointed legal guardian and have the legal right to make and/or restrict healthcare decisions regarding this child, and that my parental authority has not been terminated or restricted by the courts. I understand that is authorization will expire twelve months from the date signed.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Relationship to child: \_\_\_\_\_

**PLEASE DO NOT FAX RECORDS IF MORE THAN 20 PAGES**

NOTE: We ask that we be allowed 10 to 14 working days to process a release of medical information.