

Mountain Ridge Pediatrics

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

PURPOSE OF RELEASE: _____
 Please read all information and instructions before completing and signing this authorization form.

Child's First Name:	Child's Last Name:	Date of Birth:
		/ /

Information to be Released <u>by</u> :	Information to be Released <u>to</u> :
Organization/Person Name <hr/> Address <hr/> City State Zip <hr/> Phone Number <hr/> Fax Number	Mountain Ridge Pediatrics 2034 Pro Pointe Lane Harrisonburg, Virginia 22801 Phone: 540-217-5333 Fax: 540-217-5328

Type of Information Requested:	Dates Associated with Information:
<input type="checkbox"/> Complete Medical Record	
<input type="checkbox"/> History & Physical (admission)	
<input type="checkbox"/> Discharge Summaries	
<input type="checkbox"/> Consultations	
<input type="checkbox"/> Clinical Summaries	
<input type="checkbox"/> Lab/Radiology Reports	
<input type="checkbox"/> Diagnostic Reports	
<input type="checkbox"/> Billing Records	
<input type="checkbox"/> Immunization Records	
<input type="checkbox"/> Prescriptions	

This authorization will expire on _____ or 90 days from the set forth date below.

I hereby consent to the release of the specified information relating to diagnosis, testing, and/or treatment to the person(s) or entity named above. I understand that such information cannot be released without my informed consent.

I acknowledge that I have fully reviewed and understand the contents of this authorization form. I understand that authorization may include information relating to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV), Psychiatric Care, Behavioral and/or Mental Health services, Treatment for alcohol and/or drug abuse, and/or genetic testing. My signature below indicates that I hereby agree to and authorize the release of patient information to Mountain Ridge Pediatrics. I have the right to revoke or cancel this authorization, in writing, at any time. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility of benefits).

 Circle: Patient or Parent/Guardian Print Signature Date

 Witness Print Signature Date

PATIENTS 18 YEARS OR OLDER MUST SIGN FOR AUTHORIZATION