FAIRVIEW PEDIATRICS, LLC

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Patient Information:

Patient Name (Please Print): _____ Date of Birth: _____

Patient Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____ E-mail: _____

Name of Insurance Plan: _____

I hereby Authorize Fairview Pediatrics:

Please choose one: ☐ Release my medical record information to: ☐ Obtain medical information from:

Name/Facility: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____ Fax #: _____

Purpose of Request: ☐ Personal ☐ Referral ☐ Legal ☐ Insurance ☐ Other: _____

☐ Transfer from Practice/Reason: _____

Specific Records to be released:

☐ Please provide me with a copy of my entire medical record.

☐ Please provide the specific information as outlined below:

_____ Date(s) of Treatment: _____

_____ Date(s) of Treatment: _____

_____ Date(s) of Treatment: _____

Authorization to Release Protected Health Information:

IMPORTANT - It is extremely important that you select either **YES** or **NO** for each item contained in this section *Authorization to Release Protected Information.* Please do not skip any line item as it could impact our ability to fulfill your request and cause additional delays.

	YES	or	NO
> HIV Testing	☐		☐
> Allied Mental Health and Human Services Professional communications	☐		☐
> Genetic Testing	☐		☐
> Psychologist and Social Worker communications	☐		☐
> Substance Abuse	☐		☐
> Sexually Transmitted Diseases	☐		☐

I understand that this consent is subject to revocation at anytime unless action based on this release has already been taken. I understand that further disclosure of the information to be released may not be made without my written consent, or as otherwise restricted by Federal Regulation.

UNLESS OTHERWISE INDICATED, THIS CONSENT WILL EXPIRE IN SIX (6) MONTHS

_____

Signature of Patient/Legal Guardian Printed Name Date

For Fairview Pediatrics Use: ☐ $10 to pick up (disc) ☐ $15 to mail

Method of Payment: ☐ Cash ☐ Check ☐ Credit

Records picked up signature: _____ Date: _____