**Hometown Pediatrics**

**AUTHORIZATION FOR RELEASE OF PROTECTED PATIENT INFORMATION**



Patient Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MI \_\_\_\_\_Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Records I Would Like Released:**

* All Records From the Last Two Years (including Well Visits, Sick Visits, and Phone Messages)
* Immunization Records & Growth Chart
* Specialist Notes From the Last Two Years
* Other (Please Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I authorize the medical records listed above to be released by:**

Medical Provider Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I authorize the medical records listed above to be released to Hometown Pediatrics at:**

152 W. 2nd St., Delphos, OH 45833| |Fax: 1-833-940-3627

**I understand that:**

• I may revoke this authorization at any time, in writing, before the information has been released;

 • The released information may be released to other parties as necessary and appropriate.

**Purpose of Medical Record Release:**

* Medical Care
* Insurance Claim
* Legal Investigation
* Insurance Application
* Other (Please Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient or Parent/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***This authorization expires 1 year after the date of the signature above***