

Poole and Thomas Pediatrics, PLC

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The purpose of this form is to obtain authorization for use or release of protected health care information. Patients have the right to receive one free copy of their medical records. There will be a charge for any additional requests. You may email this completed form to jgiles@ptpediatrics.com

Patient Authorization for Use/Release of Health Care Information

I request and authorize **Poole and Thomas Pediatrics, PLC** to release health care information on the following patient(s) to:

Name: _____
(Name of individual or entity to receive this information)

Address: _____

City, State: _____ Zip: _____

Patient Name: _____ **Date of Birth:** _____

This request and authorization applies to:

_____ All health care information (Including all mental health records)

_____ Moving: New address _____

_____ All Immunization Dates & Growth Charts

_____ Health care information relating to the following
treatment, condition, or date of treatment:

_____ Other _____

Signature of Patient or Legal Guardian

Date

Print Name of Patient or Legal Guardian

Relationship to Patient

THIS AUTHORIZATION EXPIRES 60 DAYS FROM DATE OF SIGNED REQUEST.