Payne & Holloway

Authorization to Release Patient Medical Information

This authorization for use or disclosure of my child health information as required by state and federal law.

Patient's Name _____Date of Birth_____

Last First MI

Daytime Telephone _____ SS# _____

I hereby authorize the use and disclosure of my child health information **from t**he organization listed below:

FROM:

Please send records to:

PAYNE & HOLLOWAY PEDIATRICS

7006 FULTON CT MONTGOMERY, AL 36117

PHONE: (334) 244-7209 FAX: (334) 244-6604

This authorization applies to the following information:

[ ] All records [ ] Lab [ ] Immunization [ ] Chart Notes/Medical Summary

[ ] Growth Records [ ] Other _____

The recipient may use my child health information only for the following purpose (**Please specify**):

A specific authorization is required to release information regarding the following:

	Yes	No	Initials
HIV Information	[ ]	[ ]	_____
Drug/Alcohol Information	[ ]	[ ]	_____
Mental Health Information	[ ]	[ ]	_____

Authorization valid for 90 days only, and may be revoked in writing at any time prior to 90 days by notifying the office.

I understand that I have a right to a copy of this authorization requested: [ ] Yes [ ] No

Please ___Fax _____Mail _____ I will pick up the records requested.

Parent/Guardian Name (Please Print) _____ Date _____

Relationship to Patient _____Phone _____

Signature of Parent/Guardian _____ _____