AUTHORIZATION FOR RELEASE OF INFORMATION

Name of patient ____ DOB ________________

I hereby authorize ____ to release medical records information to: **Best Care Family Health Center 4220 South 27th St, Suite 200-201. Milwaukee, WI 53221. Phone 414 282-5810 Fax 414-282-5468**
E-mail bcp@bestcarepeds.com

This information may include psychiatric, psychological, alcohol, substance abuse and/or HIV related records maintained by this facility:

- ☐ All (2 years unless otherwise specified)
- ☐ History and Physical
- ☐ Newborn Records
- ☐ Prenatal/OB records
- ☐ Operative notes
- ☐ Discharge summary
- ☐ Immunization records
- ☐ Labs from ____ to ____
- ☐ Progress notes from ____ to ____
- ☐ X-rays from ____ to ____
- ☐ ED visit on ___________

This protected information is being used or disclosed to carry out treatment, payment and/or health care operations of Best Care Family Health Center in the following manner:

- ☐ Continuing care
- ☐ Insurance change
- ☐ Other

This information shall be in force and effect for one year following the date signature unless other date has been specified. I understand that I have the right to revoke this authorization in writing, at any time, by sending the notification to ______________________________________

Date _______________ ____
Signature of patient (Patient may sign if 14 years or older)

Date _______________ ____
Patient or Legal Guardian/Relationship to patient

Date _______________ ____
Witness