Pediatric Associates, Inc.

Records Release Authorization

DO NOT FAX
RECORDS
TO OUR OFFICE

PLEASE MAIL

Date:____/____/20__

I hereby authorize and request the release of information contained in the medical records of:

Patient Name:_____ DOB:____/____/____
(please **PRINT** Last name, First name)

Patient Name:_____ DOB:____/____/____
(please **PRINT** Last name, First name)

Patient Name:_____ DOB:____/____/____
(please **PRINT** Last name, First name)

Patient Name:_____ DOB:____/____/____
(please **PRINT** Last name, First name)

*Release From (Name of physician &/or group): _____
(please print)

_____
(street address)

_____
(city, state, zip)

_____
(phone#)

_____
(fax#)

Release TO: Pediatric Associates, Inc.
ATTN: ANGIE
7910 W. Jefferson Blvd.
Ste. 201
Fort Wayne, IN 46804
260-436-3789

The purpose for disclosure:

- Continuity of care
- Insurance change
- Moved
- Other(Correspondence/Exchange of information between PAI & others-see *Release Form)

Requesting ALL records (Wellness visits, Sick visits, Labs, X-rays, Hospitalization(s), Surgery, ER visits, Psych/Counseling visits, Specialists visits, Growth Charts, Immunizations)for the above named patient(s) from BIRTH-PRESENT.

I, the undersigned, understand that I may revoke this authorization at any time, in writing, but the request shall remain until revoked or upon the expiration of (60) days, whichever occurs first, except to the extent that action has been taken thereon. I understand that I am giving permission to release medical information which may include treatment for physical and/or emotional illness, pregnancy, genetic testing, communicable diseases, alcohol or drug abuse treatment, and/or HIV, AIDS, or AIDS-related information. I understand that the medical records will be mailed on an unencrypted USB unless otherwise specified above.

Patient/Legal Guardian:

Signature:_____ Date:____/____/20__

Printed Name:_____

Address: _____
(please print-street address, city, state, zip)

Phone#: _____