GREEN ROAD
PEDIATRICS, INC
Pediatric & Adolescent Medicine

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AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient Name____ Birthdate________________

I, ________________________, authorize ____

to release the following medical information to:

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Please initial appropriate box:

_______Immunizations only

_______Any and all of my medical records (as of date of release)

_______Any and all of my medical records except for the following:

____Lab, x-ray, and test results

____Any record of treatment for drug and/or alcohol dependency or abuse

____Any record of mental health treatment

____Any record of testing, care, treatment, reporting or research pertaining to HIV or related diseases.

This information is being released for the following purpose(s) only:

____

and may not be used for any other purpose or released to any other person(s) without my written consent.

This release is effective for six months from the date of execution; however I may revoke it at any time by providing notice in writing to the above named party.

_________________________ _______________
Patient (if 18 yrs of age or older) Date

_________________________ _______________
Parent/Legal Guardian of Patient (if patient less than 18 yrs of age) Date

_________________________ _______________
Witness Date