GREEN ROAD
PEDIATRICS, INC
Pediatric & Adolescent Medicine

University Suburban Health Center
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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 with HIV or related diseases.

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

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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.

____________________________________ ______________________
Parent/Legal Guardian of Patient Date

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Witness