CONSENT FOR RELEASE OF MEDICAL RECORDS

Including HIV, AIDS, & ADD/ADHD, psychiatric illness and related information

*****PATIENTS 18 YEARS OR OLDER MUST SIGN THEIR OWN RELEASE*****

1. I hereby authorize Mt. Airy Pediatrics, to release the following information from the medical records of:

   Patient name _____ Birthdate: _____
   Address _____
   _____
   Phone: _____ Social Security # _____

2. Information to be released:
   _____ Copy of complete medical record, including any testing, evaluation, treatment or correspondence, **including those records related to ADHD and/or psychiatric illness.**

3. ____ Any and all records, tests, or diagnosis of treatment for HIV, HIV-related illness, AIDS and any other communicable disease related illness. (this option must be selected for this office to release those records)

4. Reason for request: _____ leaving the practice *

   _____ to facilitate continuity of care (for specialists, or any other medical facility)

   _____ legal documentation

Information is to be released to: _____

_____

_____

Tel # _____

If you request to pick up copies of your records at our office, we will only keep the copies in our current pickup file for 8 weeks and then they will be mailed to the home address we have on file for you.

I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent and is valid for one year from date of signing. It can be revoked at any time. The facility, its employees and officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Parent/Patient/Guardian Signature_____

Relation to Patient _____ Date _____

Witness_____ Date _____

Comments: (please use this space to elaborate as necessary about your reason for leaving our practice. We appreciate any suggestions you have about how to make improvements to our practice)

_____
_____
_____
_____