CONSENT FOR RELEASE OF MEDICAL RECORDS

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

1. I hereby authorize _____

_____

_____

Tel#_____ Fax# _____

to release the following information from the medical records of:

Patient name: _____Birthdate:_____

Address _____

Phone: _____ Social Security # _____

Information to be released:

2._____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.

4. ____Hospital Records, Emergency Room visit report, Specialist Office visit correspondence, laboratory studies and x-ray reports for the following date(s) _____.

Information is to be released to:

Mt. Airy Pediatrics, PC
6673 Germantown Ave
Philadelphia, PA 19119-2252
Tel# 215-247-2996/Fax#215-247-7504

5. 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.

6. 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 _____