Child's Name _____ **Date of Birth** _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize any physician, or other healthcare professional who has attended me, or any hospital at which I have been confined, to furnish to _____ (Facility Receiving Records) or an authorized representative, any and all information that may be requested regarding my physical or mental condition and treatment rendered therefor and, if necessary, to allow them or any physician appointed by them to examine any x-ray pictures taken of me or records regarding my physical or mental condition or treatment. In addition, I also authorize the release of psychiatric/psychotherapy records, mental health records, drug and alcohol treatment, and HIV information under the same terms and conditions. A photocopy of this instrument may be used instead of the original. I also understand that this consent may be revoked by me at any time by submitting a written revocation notice, except to the extent that action has been taken in reliance thereon, and that this consent will remain in force in order to effectuate the purposes for which it is given.

I understand that my authorization will remain effective for a period of 90 days from the date of discharge or date of my request.

_____
Signature of Patient or Patient's Personal Representative/Parent/Guardian

_____
Printed Name of Person Completing this Form

_____
Date

_____
Relationship to Patient