Pediatric Associates of Madison

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
Each Patient Must Have a Separate Release Form

PLEASE PRINT CLEARLY **DATE:**_____

Patient Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Please Check One:
Sending Records to □ **Obtaining Records From** □

Physician/ Facility Name: _____

Street Address: _____

City: _____ State:_____ Zip: _____

Phone No:_____ Fax No:_____

Information to be sent or received: (check all that apply)
Entire Record _____
Immunizations _____
X-Ray Reports_____
Laboratory Reports _____
Other _____ Specify: _____

A $10 RETRIEVAL FEE AND A FEE OF .50 PER PAGE WILL BE CHARGED FOR ANY RECORDS THAT HAS TO BE RETRIEVED FROM STORAGE.

I hereby Release and Authorize Pediatric Associates of Madison, P.C. to Release the Medical Records of the dependent listed (or self 18 or over) including diagnosis, treatment, prognosis, and recommendation, as well as other data pertinent to patient's treatment to the following location listed above. I hereby state that I am the child's parent or court appointed legal guardian and have the legal right to make and/or restrict healthcare decisions regarding this child, and that my parental authority has not been terminated or restricted by the courts. I understand that is authorization will expire twelve months from the date signed.

_____ _____
Signature Date

Relationship to child: _____