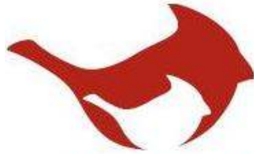

Cardinal Pediatrics, PLLC

Authorization for Release of Medical Record Information

Patient Name: ____Date of Birth: ________________

Address: ____

Phone Number: _______________________

I hereby authorize: (Please list previous physician name, address, etc.)

Name:____

Address: ____

Phone: __________________________ Fax: ________________________

to disclose information for my/my minor child's medical record to:

Cardinal Pediatrics, PLLC
1247 Suncrest Towne Centre
Morgantown, WV 26505
phone # 304 599-8000
fax # 304 599-8003

For the purpose of: ☐ Continuation of medical care ☐ payment of bill ☐ education ☐ legal purpose
☐ at the request of the patient/patient's representative for personal access, or
☐ other: ______________________________________

The specific information I wish to have released is: ☐ **Entire Medical Record**

☐ Clinic notes	☐ Consultations	☐ History & Physical	☐ Immunizations
☐ Discharge Summary	☐ Itemized Bills	☐ Laboratory Reports	☐ Medications
☐ Pathology Reports	☐ X-ray Reports	☐ other: _______________________________	

Patient initials	Parent initials	**Separate consent must be given before information related to the following conditions is released.** Please sign your initials before each applicable section.
_____	_____	Evaluation, testing, diagnosis or treatment for alcoholism and/or drug abuse, or dependence may be released to the recipient noted on the signed authorization
_____	_____	Patient testing, diagnosis or treatment for HIV/AIDS, venereal disease, or abortion may be released to the recipient noted on the signed authorization
_____	_____	Patient evaluation, testing, diagnosis or treatment concerning mental health /rehabilitation information may be released to the recipient noted on the signed authorization

I understand that I may revoke this consent at any time, in writing, except where information has already been released. This authorization is valid for a 180 day period from the date it is signed.

Signature: ______________________________________ Date: __________________
(Parent or Legal Guardian if minor child)

Witness Signature__________________________________Date:__________________