



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

**If possible, please upload records to our secure portal at
www.cardinalpediatrics.com/securemail or mail us a DVD**

For the purpose of: Continuation of medical care payment of bill education legal purposes
 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 Parent **Separate consent must be given before information related to the following**
 initials initials **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 365 day period from the date it is
 signed.**

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

Witness Signature _____ Date: _____