# Forest Hills Pediatric Associates, PC

## CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name:____________________________________________ Date of Birth______________________

☐ Please transfer my child's medical record from Forest Hills Pediatric Associates, PC to the following physician:

☐ Please send a copy of my child's medical record from Forest Hills Pediatric Associates, PC to the following consultant:

Release to: ________________________________________________
Name

________________________________________________
Address

________________________________________________
City State Zip

Medical Information To Be Sent:

☐ Entire Medical Record, *INCLUDING* information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment: information related to testing or treatment of HIV/AIDS.

☐ Entire Medical Record, *EXCLUDING* information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment: information related to testing or treatment of HIV/AIDS.

☐ Record of care from __________ to __________ *INCLUDING* information related to treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of HIV/AIDS.

☐ Record of care from __________ to __________ *EXCLUDING* information related to treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of HIV/AIDS.

☐ If deemed necessary by Doctor __________________________________, I authorize this information to be sent via fax transmission.

☐ Other ________________________________________________________________________
____________________________________________________________________________

I authorize medical information to be released as indicated above. I understand this release is effective for 6 months from the date of execution, but that I may revoke my consent at any time by providing written consent to the above named party.

| ______________________________________ | ______________________________________ |
|---|---|
| Patient signature (18years and older) or Patient's Legal Guardian | Relationship to Patient |
| Phone Number | Date |
| Witness | Date |