RELEASE OF INFORMATION

Glacier Pediatrics, LLC
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name(s): _____ Date(s) of Birth: _____
_____ _____
_____ _____
_____ _____

I authorize Glacier Pediatrics to: ( ) obtain ( ) release

( ) From ( ) To: _____

Phone number: _____

Fax number: _____

Address: ___

_____

Description of specific medical information (please check all that apply):

( ) Immunization records
( ) Physical Exams
( ) Chart notes
( ) ER reports
( ) Laboratory and x-ray reports
( ) Outside Records *

Records to be: ( ) picked up ( ) faxed ( ) mailed

I acknowledge that I have read and understand the Glacier Pediatrics, LCC Notice of Privacy Practices that describes how my health information is used and shared. I understand that Glacier Pediatrics has the right to change the notice at any time and I may obtain a current copy by contacting Glacier Pediatrics.

I understand that I have the right to revoke this authorization (except to the extent that Glacier Pediatrics has already obtained or disclosed the information in reliance of this authorization) by stating my request in writing.

_____ _____
Parent/Legal Guardian Date

Completed _____ by _____

*Excludes psychiatric records and other sensitive information