

A Bright Future Pediatrics

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Phone Number _____ Parent Name _____

I authorize and request that a copy of the following information from my medical record be released as follows:

RELEASE INFORMATION FROM:

A Bright Future Pediatrics

drberry@abfpediatrics.com

RELEASE INFORMATION TO:

Name: _____

Address: _____

Email: _____

****Purpose of Release (please specify)** _____

Records to be released (check all that apply):

____ Vaccination record ____ Lab and radiology reports
____ Well visit notes ____ Encounter notes

I understand that the medical records requested will be released via HIPAA compliant encrypted email files to the above specified email. If the accepting office is unable to accept these HIPAA compliant files, then they will be released to the parent to then transfer to the accepting office.

I understand that the information released is for the specific purpose state above and may not be provided in whole or in part to any other agency, organization, or person. I further understand that my medical records from other health care providers will not be released with this routine request. This consent will expire six (6) months after the date of signature.

I understand that my medical record may contain reports, test results and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information that has been written in the record.

I understand that I may revoke this authorization in writing at any time to the extent that A Bright Future Pediatrics has already relied on this authorization. I understand that I may revoke this authorization by providing A Bright Future Pediatrics Release of Information Department a written request for revocation stating my intent to revoke this authorization.

I will not hold A Bright Future Pediatrics liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Signature of Patient or Legal Representative

Date

Relationship to Patient