CHILD HEALTH CARE ASSOCIATES

WWW.CHILDHEALTHCAREASSOC.COM

RELEASE OF MEDICAL RECORDS

I give Child Health Care Associates permission to release records including HIV related information for:

PATIENT NAME: _____DOB: _____

PHONE NUMBER: _____

ADDRESS: _____

_____

NAME AND ADDRESS OF FACILITY OR PERSON BEING RELEASED TO:

_____

_____

_____

REASON FOR RELEASE:

☐ To obtain a copy of the immunization records

☐ Leaving the Practice; please provide reasons or comments:

☐ Insurance change ☐ Moving out of the area ☐ Dissatisfied w/physicians

☐ Billing issues /concerns ☐ Too old for pediatric practice

☐ Other/Comments: _____

_____

Parent signature if minor: _____ Date_____

Patient signature (18yr+): _____ Date _____

*THIS RELEASE WILL EXPIRE 1 YEAR FROM THE DATE SIGNED

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