Zaman Pediatric Center, P.C.

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MEDICAL RECORDS AND HEALTH CARE INFORMATION RELEASE

Authorization for Use/Disclosure of Protected Health Information

***Medical Records request must be in writing and received in our office at least 72 hours before the date needed. Please allow 10-14 days to process requests. Fees for this service are applicable and must be paid prior to releasing records.

WE CAN NOT FAX MEDICAL RECORDS

PATIENT NAME AND DATE OF BIRTH

1.___________________________________ 2.________________________________
3.___________________________________ 4.________________________________
5.___________________________________ 6.________________________________

____
CURRENT ADDRESS CITY/STATE/ZIP PHONE

Complete this section to **OBTAIN your records from another medical facility**
I hereby authorize Zaman Pediatric Center, P.C. to obtain medical records from:

Doctor/Office: ____
Phone :( )______________________________ Fax ( ) _______________________
Address: ____
City: _______________________________State: _______________Zip: ____________

Complete this section if you want to **SEND your records to another physician**
I hereby authorize Zaman Pediatric Center, P.C. to release medical records to:

Name: ____
Doctor: ____
Phone: ( ) _______________________________Fax ( ) _______________________
Address: ____
City: _________________________________State: ______________Zip: _____________

___________ Initial here if records are for personal use and not for continuation of care.

I understand this authorization includes the release of all medical records including HIV records, Psychiatric Medical illness, Drug/Alcohol abuse records, Venereal disease and any other statutory protected diseases. This authorization and consent will expire ninety (90) days following the date signed. I understand that I may revoke this authorization at any time except to the extent action has previously taken in reliance hereof.

Parent or Legal Guardian Name (Print) ____

Parent or Legal Guardian Name (Signature) ____
Date _______________________________