AUTHORIZATION FOR RELEASE OF INFORMATION

Name of patient ____DOB________________

I hereby authorize ____ to release medical records information to: **Best Care Pediatrics 4220 S. 27th St, Suite 200. Milwaukee, WI 53221. Phone No: 414 282-5810 Fax No: 414-282-5468 E-mail: bcp@bestcarepeds.com**.

This information may include psychiatric, psychological, alcohol, substance abuse and/or HIV related records maintained by this facility.

- ☐ All (2 years unless otherwise specified)
- ☐ History and Physical
- ☐ Newborn Records
- ☐ Prenatal/OB records
- ☐ Operative notes
- ☐ Discharge summary
- ☐ Immunization records
- ☐ Labs from_____to_____
- ☐ Progress notes from to
- ☐ X-rays from____ to____
- ☐ ED visit on

This protected health information is being used or disclosed to carry out treatment, payment and/or health care operations of Best Care Pediatrics in the following manner

- ☐ Continuing care
- ☐ Insurance change
- ☐ Other

This information shall be in force and effect for one year following the date of signature unless another date has been specified. I understand that I have the right to revoke this authorization in writing, at any time, by sending the notification to ____

Date ______________ ____
Signature of patient(Patient may sign if 14 years or older)

Date ______________ ____
Parent or Legal Guardian/ Relationship to patient

Date ______________ ____
Witness

Rev. 8/5/14