Bardsley Pediatric and Adolescent Endocrinology

Authorization to Release Medical Records

Patient Name: _____

Address: _____

_____

Authorization for Use/Disclosure of Information: I, the above-named patient (or the parent or legal guardian), request and authorize Martha Bardsley, M.D., LLC d/b/a Bardsley Pediatric and Adolescent Endocrinology (Provider), to provide my medical records containing the health information described below, to the recipient that I have identified below:

Recipient:

I authorize and request that my health care information to be released to the following:

Name: _____

Address: _____

Telephone: _____

Fax: _____

Information to be disclosed:

I authorize the release of the health information by checking the applicable box(es) below: (check the applicable box below)

- ❑ All of my health information that the Provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.
- ❑ Only the following records or types of health information:

  _____

  _____

  _____

Term: This Authorization will remain in effect until the Provider fulfills this request or Patient revokes this Authorization.

Redisclosure: I understand that the Provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and if I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the Provider at the address provided to me.

_____ _____

Signature Date

If Patient is unable to sign this Authorization, please complete the information below:

_____ _____

Name of Parent/ Guardian Date

Relationship to Patient: _____