



### Medical Records Release Form

By signing this form, I authorize Your Corner Pediatrics to **RELEASE** confidential health information about my child, by sending a copy of my child's medical records, or a summary or narrative of my child's protected health information to the physician/person/facility/entity listed below.

Patient name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

The information to be released is as follows:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Initial next to each selection to also include:

- |                                 |  |
|---------------------------------|--|
| _____ Mental Health Information | _____ Genetic Testing Information            |
| _____ HIV/AIDS Information      | _____ Substance Abuse<br>Diagnosis/Treatment |

Send my child's protected health information **TO** the following physician/person/facility/entity:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Description of Personal Representative