



TIMBER LANE PEDIATRICS

Authorization to Release Records

I hereby request and authorize Timber Lane Pediatrics to release any and all information contained in the medical record of the following person/persons:

_____	_____
Name	Date of Birth
_____	_____
_____	_____
_____	_____

TO

For the following reason (check all that apply)

- Leaving the area
- Dissatisfaction with office or medical care
- Change of insurance (please specify)
- Other (please specify):

Drug or Alcohol Abuse

- I DO authorize disclosure of information which refers to treatment or diagnosis of drug
 DO NOT or alcohol abuse
 N/A

Mental Health

- I DO authorize disclosure of information which refers to treatment or diagnosis of mental
 DO NOT health.
 N/A

HIV or AIDS

- I DO authorize disclosure of information which refers to HIV test results or infection
 DO NOT status
 N/A

Signed: _____

Date: _____

Relationship to Patient: _____