Valley Children's Clinic, P.C.

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AUTHORIZATION FOR RELEASE AND/OR EXCHANGE OF MEDICAL INFORMATION

I, _____, hereby authorize Valley Children's Clinic to:

___Release health information to:_____

___Receive health Information from:

Name:_____Fax:_____

Name:_____Fax:_____

Name:_____Fax:_____

Name:_____Fax:_____

___Exchange health information on an ongoing basis with: _____

_____

for the purpose of_____.

The specific records/reports to be disclosed shall include:

___Complete record
___History and Physical
___Immunizations
___Progress notes
___Other_____

___ Lab reports
___ X-Ray reports
___ Billing records

for dates of service: _____.

I understand that this consent is revocable upon written notice to VCC, except to the extent that action has already been taken on this authorization. Letters of revocation should be sent to VCC. This authorization will remain in effect until revoke in writing. Any information disclosed based on this authorization may be re-disclosed by the recipient and may no longer be protected.

I understand that I may be charged for copies of the released medical records and have been informed of the estimated cost associated with this request, if required.

Patient name: _____ Date of birth: _____
Patient name: _____ Date of birth: _____
Patient name: _____ Date of birth: _____
Signature: _____ Relationship to patient: _____
Witness: _____Date: _____
Address/phone #_____

VCC acct. #:_____