anna H. Benson, MD

Release of Medical Records

Date:______________________

This Authorization expires:__________________
(If no date is inserted, it expires one year after date signed)

Last Name ______ First Name ______ MI ______ Date of Birth ______

Address ______

Phone Number ______

I hereby authorize Mama Doc Pediatrics to

OBTAIN RECORDS FROM	RELEASE RECORDS TO
Name of Physician or Organization	Name of Physician or Organization
City State	City State
Phone	Phone

Please check one of the following:

- ☐ **Entire Medical Record** including mental health illness/diagnosis, alcohol/drug abuse/treatment, HIV/AIDS test results/diagnosis, communicable diseases.
- ☐ **Other**; Please specify:______________________________________

- I authorize the use and/or release of my child's protected health information as described above.
- I understand that there may be medical records from another doctor or facility in my chart.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
- I understand that I may revoke this authorization in writing at any time by submitting a written notice of my revocation, except to the extent that action has been taken in reliance on this authorization.
- I understand that if the person or the entity that receives the information is not covered by the federal privacy regulations, the information described above may no longer be protected by those regulations.

Signature of Parent/Guardian ______________________

Signature of Witness ______________________