

# Brentwood East Pediatrics, L.L.C.

## **AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I hereby authorize \_\_\_\_\_ to release my/my child's/children's  
medical records to \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

### **INFORMATION TO BE RELEASED**

\_\_\_\_ Initial Exam      \_\_\_\_ Discharge Summary      \_\_\_\_ Follow-up Care & Progress Notes  
\_\_\_\_ Office Notes      \_\_\_\_ ER Visit      \_\_\_\_ Special Procedure Results  
\_\_\_\_ Radiology Report      \_\_\_\_ Newborn Nursery Records      \_\_\_\_ All Medical Records  
\_\_\_\_ Other \_\_\_\_\_

The above information is released for medical purposes only. This authorization will expire thirty (30) days from the date of my signature.

With respect to any mental health information that may be contained in the patient's medical records, I hereby waive my/his/her right to the privileges of confidentiality.

\_\_\_\_\_  
Signature of patient or representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Witness Signature