Montgomery Pediatrics, Inc.

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Montgomery Pediatrics, Inc. and its agents to release information regarding:

_____ (Name of Patient) _____ (Date of Birth)

□ Release to □ Obtain From □ Discuss With

_____ (Name of Facility) _____ (Telephone)

_____ (Address) _____ (City, State, Zip)

_____ (Email Address) _____ (Fax)

This release of information is for the purpose of:

□ Moving □ Adult provider transfer □ Other (explain): _____

Type of Request

□ Record Summary □ Complete Medical Record

All record requests require 30 days from receipt of payment to process. Complete medical records are provided electronically once per calendar year at no charge. Additional requests within the calendar year are $25. Record summaries, which include the last well check, immunization records and growth charts, are provided electronically free of charge with no limit.

There is a $25 fee for all paper copies of complete medical records or record summaries. Paper copies which are requested by mail are subject to an additional $7 postage fee. Records are mailed via USPS Priority Mail with Delivery Confirmation. Families who request paper records for multiple children will only be subject to one postage fee.

Please mail my records for an additional $7 fee: _____ (Initials)

Expedite Request: Medical record requests for complete medical records and record summaries may be expedited to 5 business days for a fee of $25. I understand expedited requests for paper copies are subject to the $25 paper copy fee in addition to the expedition fee.

Please expedite my request for an additional $25 fee: _____ (Initials)

Special Authorization for release of records: (Initial all that apply)

_____ Information related to diagnosis and treatment for alcoholism and/or drug abuse or dependency

_____ Information related to diagnosis and treatment for mental health/rehabilitation

_____ Information related to HIV antibody test results and/or AIDS diagnosis and treatment

I hereby release you, your physicians, and your employees from any and all liability for fulfilling the authorization request for release of medical information. I understand that this consent is revocable by me, in writing, at any time except to the extent that action as been taken in reliance on it. I also understand that this consent will expire either ninety (90) days after the date of this signature or automatically when the records/information requested on this form has been provided to the requestor.

_____ (Date)

_____ (Printed Name of Patient/Representative)

_____ (Relationship of Representative)

_____ (Signature of Patient/Representative)