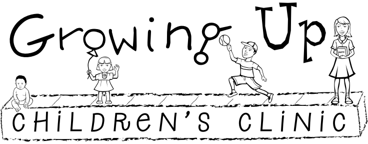

RELEASE OF MEDICAL RECORDS AUTHORIZATION

Date: ______________________________

Child's Name: ______________________________________ **(Please Print)**

Child's Date of Birth: ___________________

I hereby authorize and request Growing Up Children's Clinic to release my child's medical records to the following:

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☐ Immunization Record

☐ Growth Chart

☐ Complete Medical Record
Note: If medical record contains Highly Confidential Records (e.g. HIV results, pregnancy, STD results) a separate release form needs to be completed.

☐ Other : ______________________________
____
____
____
____

______________________________________ **Signature of Parent / Legal Guardian**

______________________________ **Date**

Daytime Phone Number: ___________________________

Intra- Office Transfer

From Site: ____________________________

To Site: _______________________________

For Office Only

Completed By: ________________

Date Completed: ______________