RELEASE OF MEDICAL INFORMATION

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Please mark one of the following:

- ☐ I am requesting records to be released from a prior physician to Southwest Children's Clinic
- ☐ I am requesting records to be released from Southwest Children's Clinic to a different office

Please provide the information of whom we are requesting from or releasing to:

Name (Physician, Clinic, Hospital or parent): _____

Address: _____

Phone: _____Fax: _____

I hereby authorize the release of the following records:

- ☐ Problem List
- ☐ Immunization Record
- ☐ Growth Chart
- ☐ Medication List

☐ Reviewed by MD

☐ Scanned/Logged

☐ Other: _____

Patient(s) Name: DOB:

1)_____ _____

2)_____ _____

3)_____ _____

4)_____ _____

I hereby authorize the release of the above-mentioned medical records and will not hold the releasing party responsible for any legal liability that may arise as a result of the release of this information.

Signature of parent or authorizing party: Please Print Name: Date:

X_____ _____ _____

Witness Please Print Name: Date:

X_____ _____ _____