

Dinosaur Junction Pediatrics
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Consent to Release Medical Information

Please allow 5 business days for us to complete this request

Records should be: Mailed OR Picked up on _____

I hereby authorize (previous doctor):

To release to (new doctor):

Name

Name

Address

Address

City, State, Zip Code

City, State, Zip Code

Phone Number

Phone Number

This is to authorize you to release the requested information on the below named individual(s).

Please list one person per line.

Patient Name(s):

Date of Birth:

Information Requested:

- Complete Records
- Limited Records (Dates: _____)
- Health Information Relating To: _____
- Immunization Records

Reason:

- Consult
- Moving
- Insurance
- Age of Patient
- Changing Doctors

Reason: _____

I request and authorize the above named provider(s) to release this information. I understand the records may include information regarding the following conditions: drug or alcohol abuse, psychological or psychiatric conditions, developmental disabilities, HIV, AIDS, sexually transmitted diseases, pregnancy, or other sensitive information. This authorization will expire 120 days from the below date.

Patient of Legal Guardian Signature

Date

Printed Name

Relationship to Patient