Richmond Pediatrics
Pediatric & Adolescent Medicine
... for over 40 years

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

To: _____ _____
doctor/clinic/hospital telephone number

_____ _____
street or P.O. box fax number

_____
city, state, zip code

I hereby authorize the above named to release a complete copy of medical records in your possession to the Richmond Pediatric Clinic. I understand that this authorization extends to all aspects of medical care including testing, diagnosis, and treatment for the patient or patients listed below.

I understand that these records may contain information regarding the diagnosis or treatment of HIV, other sexually transmitted diseases, drug or alcohol abuse, mental illness or psychiatric treatment. I give my authorization for these records to be released.

Patient Name(s):_____ Birthday:_____
Patient Name(s):_____ Birthday:_____
Patient Name(s):_____ Birthday:_____
Patient Name(s):_____ Birthday:_____

Authorized Signature:_____ Date:_____
Approximate Date Last Seen:_____
Additional Comments:_____

Please send records to: Richmond Pediatrics
357 NW Richmond Beach Road
Shoreline, WA 98177
Telephone: (206) 546-2421 Fax: (206) 546-8436

This authorization expires 90 days after the date it is signed.