Bear Creek
PEDIATRICS

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Please note that there may be a fee associated with providing a copy of your medical record.

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

I request and authorize BEAR CREEK PEDIATRICS to release healthcare information regarding the named patient to:

Name/Medical Facility: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip: _____

INFORMATION TO BE RELEASED

- ☐ All Healthcare Records
- ☐ Immunization Records
- ☐ Other: _____

PURPOSE FOR WHICH DISCLOSURE IS MADE

- ☐ Transferring Care
- ☐ Personal Copy
- ☐ Other: _____

I hereby consent to the release of the above information. I understand that such information cannot be released without my consent. I understand that this authorization expires 90 days after date signed. I understand that I may revoke this authorization at any time by notifying Bear Creek Pediatrics in writing and that it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

YOUR SIGNATURE BELOW CONFIRMS THAT YOU UNDERSTAND AND AGREE TO THE TERMS OUTLINED.

_____ _____

Signature of Patient or Legal Representative* Date

_____ _____

Print Name of Patient or Legal Representative* Relationship to Patient

*If the patient is a minor but is authorized to consent to healthcare without parental consent under federal and state law (age 13 and above for drug and alcohol information; age 14 and above for sexually transmitted disease information, including HIV/AIDS; and age 13 for mental health information) only the patient shall sign this authorization form.