NORTHERN LIGHTS PEDIATRIC
& ADOLESCENT MEDICINE

Release of Information

Patient Information	**Name:** _____ **Date of Birth:** _____ **Address:** _____ **Phone Number:** _____ **City:** _____ **State:** _____ **Zip:** _____
Clinic/Hospital/Health Care Provider (**Who** has the information you want released?) **Please list the specific clinic and/or hospital.**	**Name:** _____ **Address:** _____ **Phone:** _____ **City:** _____ **State:** _____ **Zip:** _____ **Fax Number:** _____
Receiving Party (**Where** do you want the information sent?)	**Name:** _____ **Address:** _____ **Phone:** _____ **City:** _____ **State:** _____ **Zip:** _____ **Fax Number:** _____
Information to be Released (**What** do you want sent or released? Check the appropriate box.)	□ Specific dates/years of treatment _____ □ ALL health records **Or** ONLY records types checked below □ History/Physical □ Progress notes □ Consultations □ Lab report □ Care Plan □ Other information or instructions _____ □ Medication □ Immunizations _____ □ Mental health □ Radiology Repots
Release Instructions	Date information is needed: _____ (Please allow 7-10 days for processing)
Purpose of Release	□ Continuation of Care by specialist □ Insurance □ Transfer of Care □ Personal Use □ Other _____

- This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____
- This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation.
- Northern Lights Pediatrics will not restrict my treatment if I choose not to sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- Only one free copy of records will be released (unless requested by a specialist, insurance company, or lawyer), if subsequent records are needed there may be a charge.
- Northern Lights Pediatrics records may include records that it received from other organizations. If these records have been used by Northern Lights Pediatrics authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Northern Lights Pediatrics from any and all liability resulting from a re-disclosure by the recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

_____

Patient/Legal Guardian Signature Date Relationship to Patient