Pack Pediatrics, LLC
5301 Reno Corporate Drive
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Medical Record Release Form

Patient Name:_____ Date of Birth:_____
Patient Name:_____ Date of Birth:_____
Patient Name:_____ Date of Birth:_____

I authorize the release the records of my child(ren) to include:

- ○ All Records (entire file)
- ○ Growth Charts
- ○ Well Visits
- ○ Sick Visits
- ○ Lab/Pathology Records
- ○ Xray/Radiology Records
- ○ Billing Records
- ○ Pharmacy/Prescription Records
- ○ Other (please specify): _____

Purpose of record release:
□ Healthcare Coordination □ Transfer of Care □ Personal □ Other: _____

I authorize Pack Pediatrics to obtain information FROM:	I authorize Pack Pediatrics to release information TO:
_____ _____ _____ Phone: _____ FAX:_____	_____ _____ _____ Phone: _____ FAX:_____

I understand that:

- Authorizing the disclosure of this health information is voluntary. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.
- I may cancel this authorization at any time by submitting a written request, except where disclosure has already been made in reliance on my prior authorization. I understand that the revocation will not apply to any information that has already been released in response to this authorization.

Name of Patient's Parent/Legal Guardian:

_____

Signature of Patient's Parent/Legal Guardian:

_____

Relationship to Patient: _____ Date: _____