



COMPLETE CHILDREN'S HEALTH, P.C.

AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

_____ / ____ / ____
Patient Name: Last First MI Date of Birth

The undersigned hereby authorizes:

COMPLETE Children's Health
Medical Records
Phone: 402-327-6008
FAX: 402-327-6092

To Release Information to:

Name: _____
Address: _____

Phone: _____
Fax: _____

Reason for Release: _____

Release the following Health Information:

- Entire Medical Record
- Inclusive Dates Only ____/____/____ through ____/____/____
- Immunization Records
- Other _____

I authorize the health care provider to release the information specified below to the recipient of this request. I specifically authorize the release of information regarding the following conditions:

Initials:

_____ Drug abuse if any _____ Psychological or psychiatric conditions if any
 _____ Substance abuse if any _____ AIDS/HIV if any

Expiration or revocation of authorization I understand that I may revoke this authorization at any time.

Use of copies A copy of this authorization may be utilized with the same effectiveness as an original.

Reimbursement Complete Children's Health, P.C. reserves the right to recover costs involved in producing the requested information. You or the recipient of the records may be charged \$20 plus 50 cents per page for handling and copying this information.

 Printed Name Date Phone number if questions

 Signature Relationship to Patient