BEAUFORT PEDIATRICS

MEDICAL INFORMATION RELEASE FORM

Patient Name: _____ Patient DOB: _____

Records to be released from:

_____

_____

_____

Phone: _____

Fax: _____

Records to be Mailed/Faxed/Emailed to:

_____

_____

_____

Phone: _____

Fax: _____

Email: _____

PLEASE SEND A COMPLETE MEDICAL RECORD FOR THIS CHILD. ALL DATES TO BE INCLUDED.
CDs NOT ACCEPTED.

My signature below authorizes the release/receive all personally identifiable data as indicated in reference to my child.
I understand that this authorization may be revoked in writing at any time unless action has been taken in reliance of this authorization. This authorization expires after one calendar year unless otherwise revoked in writing.
Beaufort Pediatrics PA, the Physicians, Staff and officers are hereby released from any legal responsibility or liability for disclosure of this information as indicated in this authorization. I fully understand and accept the terms of this authorization.

_____ _____

Signature of Parent/Legal Guardian Date

Date Request Sent: _____

Faxed/Mailed: _____

Scanned by: _____