

AUTHORIZATION TO RELEASE MEDICAL BILLING/
PERSONAL MEDICAL INFORMATION

DATE: _____

I _____ Do/Do Not give permission to
Dr _____ and/or Garden City Pediatrics office

staff to speak to _____,

relationship: _____ regarding my:

- Medical Billing info
- Personal medical information

I am authorizing the release of the following information (check all that apply)

- all records
- all records except _____
- only records related to: _____
- records of treatment from: _____ to: _____
- sensitive information (drugs and/or alcohol abuse, psychiatric care, sexually transmitted diseases, other sensitive information)
- HIV (AIDS) testing/treatment records

This authorization is voluntary and may be revoked at any time by informing us in writing. I understand this authorization will expire:

- indefinitely
- other _____

Patient name

DOB

Patient Signature

Date