Authorization for Release/Disclosure of Records/Information

Patient's name:_____Telephone:_____Birthdate: _____

Address:_____City:_____ State:_____Zip: _____

I hereby authorize the release/request of copies and/or discussion of the specified information included in my medical records that are in your possession. I understand that record requests may take up to 10 business days to process. Furthermore, I understand that if my request lacks any of the information requested below, the processing time may be significantly delayed. A reasonable fee may be charged for duplication of records. An estimate of those charges that can range from $10,$30 and $50 dollars will be provided upon receipt of the request if applicable.

Description of Information to be released: Disclosure is authorized for any and all information about medical history, mental and physical condition, including, educational, behavior analytic, occupational, and speech therapies. Genetic testing, chromosome analysis, sickle cell anemia, labs, HIV infection, AIDs, or ARC, drug and alcohol use, and other personal information unless otherwise specified.
Melmed Center office visit notes will never be included in a release unless specified. **Initial:** _____

Description of information to be released/exchanged:

☐ **Developmental Evaluations** ☐ **Psychological Evaluations** ☐ **Lab Results** ☐ **Educational Information**

☐ **Other** _____

Delivery Method: ☐ **Mail** ☐ **Pick-up** ☐ **E-mail:**

Authorized Release:
☐ **Paper records** ☐ **Verbal/Exchange of information**

Purpose of Release:
☐ **Continuity of medical care** ☐ **School** ☐ **Personal use** ☐ **Legal**

( ) Release of information from Melmed Center/ To

( ) Request of Information to be released to Melmed Center/ From

_____
Name of Person/ Agency/ Institution

_____
Address
City State Zip

Telephone Number Fax number Email

I certify that this request has been made voluntarily and that the given information above is accurate to the best of my knowledge. By my signature below, I further declare that I have the legal authority to grant the above permission. I understand that I have the right to revoke this authorization, provided that I do so in writing, except to the extent that Melmed Center has already used or disclosed the information in reliance to this authorization. I understand that once the records and information authorized herein are disclosed to entities or persons outside of Melmed Center, they could be re-disclosed by the recipient(s) and may no longer be protected by the Family Educational Rights and Privacy Act (FERPA), Health Insurance Portability and Accountability Act of 1996 and/or other state or federal laws and regulations. **This authorization will expire only upon completion of a consent revocation form.**

_____ _____
Name of Patient (Please Print) Today's Date Telephone

_____ _____
Signature of Patient/Parent/Legal Guardian Relationship to Patient

8/23/23 Revision