Release of Information Authorization

Name: _____
(Last) (First) (Middle)

Date of Birth: _____/_____/_____
(mm) (dd) (yyyy)

I authorize _____ to release the information selected below to:
(Name of Doctor / Medical Group / Hospital / Organization / etc.)

Welcome Pediatrics PLLC.

Please check all that apply:

- ☐ Complete Medical Records
- ☐ Lab Reports/Results
- ☐ X-Ray and Diagnostic Reports
- ☐ Infant Screen (PKU) and Birth Records
- ☐ Other: _____

I understand that the records listed above are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written authorization unless otherwise provided for in the regulations.

Signature: _____ Date: _____/_____/_____
Patient's Legal Guardian Relationship to Patient (mm) (dd) (yyyy)

Signature: _____
Witness

Prohibition on Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal confidentiality rules (42 CFR part 2). Federal rules prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains, or as otherwise permitted by State or Federal law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.