Release of Medical Records

I hereby authorize the disclosure of the named individual's health information as described below:

Patient Name: _____ DOB: ___/___/___

The following individual or organization is authorized to make the disclosure:

Suburban Pediatrics, Inc.
456 N. New Ballas Rd., Suite 304
St. Louis, MO 63141
(314) 567-6868

The information may be disclosed to and used by:

(Enter the Name and Address of the New Physician)

_____

_____

_____

Treatment Dates: _____ to _____

The following information is to be disclosed:

Yes	No	
___	___	Physician Notes
___	___	Immunization Record
___	___	Lab Results
___	___	X-Ray/Diagnostic Report
___	___	Complete Record

Sensitive Information: I understand that the information in this record may include information relating to behavioral or mental health services, or other information of a sensitive nature such as testing for sexually transmitted diseases or drugs.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. My revocation must be in writing, and cannot apply to information already released based on this authorization.

Expiration: Unless otherwise specified or revoked, this authorization will expire six months from the date signed.

_____ Date ___/___/___
Signature of Patient, Parent, or Legal Representative