CHILD & TEEN Wellness Center

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AUTHORIZATION FORM TO RELEASE MEDICAL RECORDS

I _____ hereby voluntarily authorize the disclosure of information from my health record to be released to:

Child & Teen Wellness Center
10085 Red Run Blvd Suite #201
Owings Mills, MD 21117
Phone: 410-363-1843
Fax: 410-363-3027

Patient Name: _____DOB: _____
Address: _____
City: _____State: _____ Zip: _____
Phone: _____

INFORMATION TO BE RELEASED:

☐ Complete Medical Record or ☐ Immunization Record
☐ Growth Chart
☐ Last Physical Exam

☐ I specifically authorize the release of information relating to:
- ☐ Substance Abuse
- ☐ Mental Health
- ☐ HIV/AIDS

Purpose of Disclosure:

I understand that this authorization will expire 1 year after I have signed the form. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.

_____ _____
Signature of Responsible Parent/Legal Guardian *Date*

OFFICE INFORMATION

Provider: _____ Phone: _____Fax: _____
Date Requested: _____ Initials: _____