

Records Needed by: _____

Patient Name: _____ Pt. D.O.B.: _____ MR#: _____

****Please include a copy of this form with the materials requested****

I authorize the release of information and report(s) to the individual/party as stated below:

<input type="checkbox"/> Release TO Gillette Children's Specialty Healthcare Requested By: _____	<input type="checkbox"/> Release FROM Gillette Children's Specialty Healthcare ATTENTION: _____
Contact: _____ Facility: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Phone: _____ FAX (if known): _____	
<input type="checkbox"/> Verbal Release Only, to: _____	

Information to be Released: Check the appropriate box(es) below regarding information to be released for the following dates:
From: _____ to _____

<input type="checkbox"/> Records Pertaining to: <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Laboratory Report(s) <input type="checkbox"/> Operative Report(s) <input type="checkbox"/> Pathology Report(s) <input type="checkbox"/> History & Physical Exam <input type="checkbox"/> Consultation Report(s) <input type="checkbox"/> Outpatient Clinic Notes <input type="checkbox"/> Special Testing <input type="checkbox"/> Imaging Report(s) – (X-ray, CT, MRI, etc.) <input type="checkbox"/> Birth record/NICU notes	<input type="checkbox"/> Other – (Please specify individual options) <input type="checkbox"/> Imaging Exam(s) – (X-ray, CT, MRI, etc.) <input type="checkbox"/> Discharge Instructions <input type="checkbox"/> Growth Charts <input type="checkbox"/> School/Academics/IEP <input type="checkbox"/> Media (photos, videos, and other diagnostic imagery) <input type="checkbox"/> Rehabilitation Report(s), specify: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Therapeutic Rec <input type="checkbox"/> Initial and most recent eval and last progress note <input type="checkbox"/> Other:
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* The following information will not be released unless initialed by patient or legal guardian:
 _____ Psychiatric / SW Discharge _____ Psychology Evaluation _____ AIDS /HIV _____ Chemical Dependency

Please indicate any release restrictions: _____

Information to be Disclosed will be used for Continuing Care

I understand that:

- I may revoke this authorization at any time by **WRITTEN REQUEST**.
- Revoking my authorization will **NOT** apply to information already released in response to this authorization.
- A photocopy or facsimile of this authorization will be treated in the same manner as if it were the original form.
- Once information is released because of this authorization, Gillette cannot prevent re-disclosure of the information by a third party.
- Gillette may not make treatment, payment, enrollment or eligibility for benefits a condition of my signing this form.

This authorization will expire **ONE YEAR** following the date of signature except in the case of continuing care. Information released only includes information up to the date of signature.

(All lines must be completed)

Please sign here

 Patient/Parent of minor/Legal Responsible party *Relationship Date
 *Proof of Guardianship/Durable POA/court order may be required

----- (Office Use Only) -----

Date Received: _____ Date Processed: _____ Request Completed by: _____