Medical Records Release Form

By signing this form, I authorize you tot release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the provider/person/facility/entity listed below.

Patient Name: ____________________________________ Date of Birth: ______________________

The information you may release subject to this signed release form is as follows:

☐ Complete Records ☐ Immunization Record ☐ Lab/Radiology Reports

☐ Hospital Records

Release my protected health information to the following provider/entity:

Lively Pediatrics, PLLC

Fax #: 855-618-2212

Address: 608 New Hope Road, Suite 7 / Princeton, WV 24740-2287

Phone #: 304-913-3160

*****Enter Medical Provider Info From Whom We Are Requesting Records Below*****

I authorize the following Provider/Facility/Enity to release information designated herein:

Name: ____

Fax #: _____________________________________

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____ ______________________

Signature (Parent/Personal Representative if under age 18) Date

____

Print Name

____

Relationship to Patient (i.e. Mom, Dad, etc)