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Lincoln Pediatric Associates, Inc.

www.lincolnpedi.com

AUTHORIZATION TO RELEASE/OBTAIN HEALTHCARE INFORMATION

Patient's Name: _____ **Date of Birth:** _____

I request and authorize _____

To release healthcare information of the patient named above to:

Name:_____

Address:_____

City:_____ **State:** _____ **Zip Code:** _____

Phone:_____**Fax**_____

Reason for Transfer: _____

This request and authorization applies specifically to:

☐ **All healthcare information**

☐ **Healthcare information relating to the following treatments, condition, or dates:** _____

_____

☐ **Other:**_____

☐ **Please exclude the following Healthcare Information:**

- ☐ **Mental Health related information**
- ☐ **Substance Abuse related information**
- ☐ **HIV/AIDS Related information**
- ☐ **Other:**_____

Signature of guardian if patient is under the age of 18: _____ **Date:** _____

Signature of patient if the patient is age 18 or older: _____ **Date:** _____

Please note

This authorization expires 90 days after it is signed

Please be advised that a photocopying fee may apply