TANQUE VERDE PEDIATRICS

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WWW.TANQUEVERDEPEDS.COM

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT NAME:	**DOB:**	**DATE:**
PARENT/GUARDIAN NAME:		
ADDRESS		**PH NUMBER: ( ) -**

PLEASE CHECK ONE:

	THIS AUTHORIZES **TANQUE VERDE PEDIATRICS** TO RELEASE INFORMATION TO:		THIS AUTHORIZES **THE BELOW FACILITY** TO RELEASE INFORMATION TO TANQUE VERDE PEDIATRICS:

NAME: _____

ADDRESS: _____

PHONE: _____ FAX: _____

EMAIL: _____

RECORDS TO BE RELEASED

(Please check all that apply)

	ALL RECORDS		LABS ONLY
	MENTAL HEALTH RECORDS SIGNATURE REQUIRED: _____		OFFICE NOTES ONLY
	SPECIFIC DATES OF SERVICE		OTHER: _____

This authorization shall remain in effect for 60 days from the date of signature unless a different date is specified here _____ (date). You or your representative can revoke this authorization upon written request. If you revoke, it will not affect the information disclosed before the receipt of the written request. The actual treatment records from mental health are specifically protected and will not be disclosed unless you sign above.

_____	_____	_____
Parent Printed Name	Parent Signature	Date

IN OFFICE USE ONLY:	
RECORDS PREPARED/TRANSMITED BY:	SIGNATURE:
DATE:	COMMENTS:

Updated 07/2022