Uptown Pediatrics
Two-Way Authorization for the Release of Information

****Note: Please fill out and sign both pages of consent form****

First Name: _____ Last Name: _____ DOB: _____

I, _____, hereby authorize Uptown Pediatrics to disclose my protected health
Patient or guardian if patient is a minor
information to _____, as described below, for the purpose of evaluation,
Name of practitioner or clinic/hospital name
treatment, and collaboration of care.

Information to be released (please select at least one if consenting to release):

[ ] Full medical record (including all components listed below)

If you do not want to release the full medical record, please select components that you do consent to release

[ ] Discharge or closing summary
[ ] Laboratory reports (all except _____)
[ ] Medical history and physical exam
[ ] Social service reports
[ ] Progress reports
[ ] Treatment records
[ ] Admission/Intake Summary
[ ] Psychiatric evaluation
[ ] Psychological testing or evaluation
[ ] Social history, including substance use history
[ ] Emergency room reports
[ ] Immunization records
[ ] Birth history
[ ] Court records
[ ]Chemical dependency evaluation

Uptown Pediatrics
Two-Way Authorization for the Release of Information

I, _____, hereby authorize _____ to disclose my protected
Patient or guardian if patient is a minor *Name of practitioner or clinic name*

health information to Uptown Pediatrics, as described below, for the purpose of evaluation, treatment, and collaboration of care.

[ ] Full medical record (including all components listed below)

If you do not want to release the full medical record, please select components that you do consent to release

[ ] Discharge or closing summary
[ ] Laboratory reports (all except _____)
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[ ] Emergency room reports
[ ] Immunization records
[ ] Birth history
[ ] Court records
[ ]Chemical dependency evaluation

I understand that State and Federal privacy laws protect my records. My records can be released only if I give my written permission or if the law allows it. If I refuse to sign or cancel this release, I may not be eligible to receive the service I am requesting. I may cancel this consent with written notice at any time, but that this written notice will not affect information the agency has already requested or released.

_____ _____
Patient or Child's name Date

_____ _____
Patient or Guardian Signature (if child is a minor) Parent or Guardian Name