FULL BLOOM PEDIATRICS

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PLEASE FAX RECORDS TO 575-532-9049 OR
EMAIL RECORDS TO
contact@fullbloompediatrics.com

MEDICAL RECORDS RELEASE

_____ here in after "RELEASOR" hereby authorizes
Name of Parent or Guardian

_____
Name of Doctor, Clinic, or Facility records are being requested from. Phone Number and/or Fax Number

to release any and all medical records including, but not limited to, psychological, psychiatric, alcohol and drug treatment and laboratory reports including HIV testing data in the case of :

_____ _____ _____ _____
Name of Patient Date of Birth Name of Patient Date of Birth

_____ _____ _____ _____
Name of Patient Date of Birth Name of Patient Date of Birth

To: Full Bloom Pediatrics

This authority to release includes, but is not limited to: medical reports, clinical notes, nurse's notes, history of injury, subjective and objective complaints, x-rays, x-ray reports, interpretations of a diagnostic test (including a copy of the report), diagnosis and prognosis; if applicable, emergency room records or logs, history of physical examination reports, laboratory reports, tissue committee reports, reports of operation, operation log, progress notes, doctor's orders, physical therapy records, admission and discharge summaries and all out-patient records, hospital bills, bills for the services you have rendered, bills for medication and so forth, and any other document records or information in your possession relative to any past, present, or future physical and mental condition.

IN ADDITION, IT IS SPECIFICALLY ACKNOWLEDGED BY RELEASOR THAT SUCH RECORDS MAY INCLUDE AND/OR CONTAIN REFERENCE TO ANY OR ALL OF THE BELOW, NONETHELESS DIRECTS THAT ALL OF THE FOLLOWING MATERIALS ALSO BE RELEASED AS SPECIFIED HEREIN.

(a) Any and all medical records/reports/documentary materials/tangible materials, which relate, in any way, to the drug/alcohol/substance abuse history, if any, of the above named patient(s).

(b) Any and all medical records/reports/documentary materials/tangible materials, which relate, in any way, to the emotional/mental health/psychiatric condition, if any, of the above named patient(s).

(c) Any and all medical records/reports/documentary materials/tangible materials, which relate, in any way, to the Human Immune Deficiency Virus (HIV) infection/testing and/or to Acquired Immune Deficiency Syndrome (AIDS), if any, in the case of the above named patient(s).

The information which related to section (c) is to be released under section 24-2B-7 and this authorization to release information to FULL BLOOM PEDIATRICS, is subject to the following statement: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making further disclosure of such information without specific written consent of the person to whom the information pertains or is otherwise permitted by state law.

A photocopy of this authorization, which contains my signature, shall be considered as effective and valid as the original and shall be honored by those to whom it is provided. This form will be in effect indefinitely regarding the release of this specific set of records unless revoked by me in writing. I recognize my right to refuse to sign this release.

_____ _____
Signature of Releaser (Parent or Guardian) Date