## Medical Record Release

**I do hereby consent and authorize Purple Crayon Pediatrics to release and receive copies of my medical records.**

Patient Name: ______________________________ DOB: __________

Address: ______________________________

City: ______________________ State: __________ Zip Code: __________

**Record requested to/from:**

Name of person or facility: ______________________________

Address: ______________________________

City: ______________________ State: __________ Zip Code: __________

Purpose of request: ______________________________

**Please select all the documents that apply:**

- ❏ Entire Medical Record
- ❏ Clinical Notes
- ❏ Progress Notes
- ❏ Discharge Summary
- ❏ Labs/Pathology Reports
- ❏ Operative Notes
- ❏ Emergency / Urgent Care Notes

**Initial beside the options below to authorize the release of sensitive information pertaining to:**

______________ Mental Health

______________ Drugs and/or Alcohol

______________ Genetic Testing

______________ HIV/STD Disease Testing

______________________________
Patient Signature if older than 18

______________
Date

______________________________
Parent / Legal Guardian if under 18

______________
Date

- ❏ Mail to address above
- ❏ Pick up when ready
- ❏ Urgent Fax to: ______________

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