Ogden Pediatrics

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# Records Release Form

Patients Name_____, Date of Birth_____

I authorize Dr. Klier, of Ogden Pediatrics to transfer my medical records to:

Name and address: _____

_____

_____

_____

Reason for record release_____

Please note: all records will be sent **except** those containing information regarding HIV, Alcohol/Drug or Mental Health issues (unless we are authorized by law to forward this information on). If you would like this information included, please specify what you would like sent and sign on the appropriate line. Selected items to include:

Please send medical records regarding HIV information
(signature)_____*(A separate form is required for release of this documentation. Please request a form from this office).*

Please send medical records regarding Alcohol/Drug information
(signature)_____

Please send medical records regarding ADHD/ADD and Mental Health information
(signature)_____

_____

_____ _____
Signature of Parent / **Patient (if 18 yrs. or older)** Date

_____ _____
Printed Name of Parent / **Patient (if 18 yrs. or older)** Relationship to Patient

_____ _____ _____
Witness Printed Name Signature Date