Willow Tree
PEDIATRICS

P: 256.735.4632 F: 256.735.4639
1167 COUNTY RD 437, SUITE B
CULLMAN, AL 35055

# Medical Records Release Form

By signing this form, I authorize _____ to release confidential health information, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below. Your authorization allows the party listed to release your personal health information to Willow Tree Pediatrics. Upon written notice you may see or obtain a written copy of health information provided to Willow Tree Pediatrics. You may revoke this authorization at any time by submitting a request in writing to Willow Tree Pediatrics.

Patient Name: _____ Date of Birth: _____

THE INFORMATION YOU MAY RELEASE SUBJECT TO THIS SIGNED RELEASE FORM IS AS FOLLOWS:

| | | |
|---|---|---|
| ____ Complete Records | ____ Lab Reports | ____ Radiology Reports |
| ____ History & Physical | ____ Pathology Reports | ____ Operative Reports |
| ____ Progress Notes | ____ Hospital Reports | ____ Medication Reports |
| ____Care Plan | ____ Other (specify below) | |

The purpose/reason for this release is as follows:

_____

Release my protected health information to the following physician/person/facility and/or those directly associated in my medical care:

Willow Tree Pediatrics, Dr. Heidi Blair

1167 County Road 437, Suite B, Cullman, AL 35055

Phone: (256) 735-4632 Fax: (855) 399-3429 or (256) 735-4639

I understand that revoking this authorization does not affect actions taken by Willow Tree Pediatrics prior to my written notice. I understand that signing this authorization for disclosure of health information is voluntary. I understand that this authorization may include sensitive records such as information concerning sexually transmitted disease, alcohol or drug abuse, behavioral and mental health services, and acquired immunodeficiency syndrome (AIDS) or human immunodeficiency syndrome (HIV).

Parent/ Guardian Signature: _____ Date: _____