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Harmony Mills Pediatrics

Medical Records Release Consent Form

Patient

Name (Last, First, MI)	Date of Birth

Responsible Party

Name (Last, First, MI)	Relationship to Patient

I, the above named responsible party:

❑ authorize the following party to release all indicated medical records and documents to Harmony Mills Pediatrics:

❑ authorize Harmony Mills Pediatrics to release all indicated medical records and documents to the following party:

Party Releasing or Receiving Medical Records

Party Name	Primary Care Physician's Name (if applicable)			Phone
Party Address	City	State	Zip Code	Fax

This request explicitly includes the following categories of documentation:

❑ All Records ❑ Lab Work Only ❑ Other _____

For the purpose of:

❑ Continued Treatment ❑ Legal Review ❑ Insurance-related purposes

❑ Transfer of Primary Medical Care ❑ Personal Review of Information

❑ Other _____

This form is considered valid for one year after the date of signature or until _____, whichever is earlier.
date of expiration (optional)

Guarantor Signature: _____ Date: _____