



South Lake Pediatrics
Infant, Child & Adolescent Care

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Patient Account Services
952-401-8282

REV. 3/09

AUTHORIZATION AND CONSENT FOR THE
RELEASE OF MEDICAL INFORMATION

I hereby Authorize and request South Lake Pediatrics to release or request medical
records for:

PATIENT LAST NAME FIRST MI DOB: MM/DD/YY
DOB:
DOB:
DOB:
DOB:
DOB:

Father: Mother:
(Or legal guardian(s))

FORWARDING ADDRESS (IF APPLICABLE)

REQUESTING RECORDS FROM: (Clinic/physician and address)

PURPOSE FOR RELEASE:

\_\_\_ Moving to: \_\_\_
\_\_\_ Switching Clinics
\_\_\_ Insurance change to: \_\_\_
\_\_\_ Consultation/Specialist
\_\_\_ Legal (need cover letter)
\_\_\_ Other (Please specify): \_\_\_

SEND RECORDS TO: (Clinic/physician and address)

SPECIFIC INFORMATION REQUESTED OR REQUESTING:

\_\_\_ office visits \_\_\_ X-ray reports \_\_\_ Lab reports
\_\_\_ Immunization date \_\_\_ Growth Charts
\_\_\_ Other (specify):
Date: from \_\_\_ to \_\_\_

SEE REVERSE SIDE FOR REQUIRED SIGNATURES

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\*Patients 18 years of age or older are legally required to sign authorization.

**ACKNOWLEDGEMENT OF UNDERSTANDING:**

- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.
- I understand that in compliance with MN statute 144.33 and WI Administrative Code HHS117, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.

**AUTHORIZATION FOR USE AND DISCLOSURE OF  
PROTECTED HEALTH INFORMATION**

**Specific authorization for release of information protected by State or Federal Law**

I specifically authorize for the release of information relating to:

- Substance abuse (alcohol/drug abuse) \_\_\_\_\_
- Mental Health (psychological testing) \_\_\_\_\_
- HIV-related information (AIDS-related testing) \_\_\_\_\_
- Developmental Disabilities \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature required for above tests

\_\_\_\_\_  
Date

The last 2 years of office visits plus 1 year of lab and x-ray will be sent unless it is otherwise stated or related to a specific illness. There is a fee for more than 2 years of records.