Jennifer Danielson, MSN PNP-BC

Greg Suchon, MD

RELEASE OF RECORDS REQUEST

Release From:	Release To:
Doctor's Name:	Doctor's Name:
Office Name:	Office Name:
Address:	Address:
Phone Number(s):	Phone Number(s):
Fax Number(s):	Fax Number(s):

I authorize release for the following:

Child's Name	Date of Birth

Covering the period of service from:

O Birth to present
O Dates of service _________ to __________

Only records generated through the Northside Child Health Center will be released. This does not include records from outside sources.

I request and authorize the release of information to the organization, agency, or individual named above. I understand that the information to be release may include the following condition(s):

Drug abuse/alcohol abuse (federal regulation 42 C.F.R, part 2)
Psychological/psychiatric conditions
A test for HIB (AIDS) virus
An AIDS diagnosis and/or AIDS related conditions

I hereby release the Northside Child Health Center and personnel from all legal responsibility and liability that may arise from the records released that I have authorized above.

____

Signature of Parent/Guardian | Relationship to patient | Date Signed

____

Address of Above Parent/Guardian | Phone Number of Parent/Guardian