RIGHT from the START PEDIATRICS
9423 Holy Cross Lane
Suite 111, Physician Office Building
Breese, IL 62230
Phone 618-526-8850 Fax 618-526-8852

CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION

I hereby authorize Dr. Morra to release to / receive (please circle which is applicable) from:

_____ (Facility / physician / agency)

_____ (Street / city / state / zip code)

_____ (Phone number / fax number)

The following information contained in the record of _____,

Born on ___/___/_____, and residing at _____

[ ] The entire medical record, excluding mental health treatment, alcohol use/abuse treatment, drug use/abuse treatment, and HIV / Acquired Immune Deficiency Syndrome (AIDS) records
[ ] Mental health treatment records
[ ] Alcohol use/abuse treatment
[ ] Drug use/abuse treatment
[ ] HIV / AIDS records
[ ] Laboratory reports
[ ] X-ray reports
[ ] Operative notes
[ ] Correspondence
[ ] Other

The above information for the following period of time shall be released:

From _____ To _____

The purpose(s) of this authorization is (are) _____

_____

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will NOT be disclosed, except as provided by law.

SIGNATURE OF PARENT / GUARDIAN OR ASSIGNED REPRESENTATIVE RELATIONSHIP TO CHILD

PRINT NAME DATE