# Mack and Poole Pediatrics, PLC

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The purpose of this form is to obtain authorization for use or release of protected health care information. Patients have the right to receive one free copy of their medical records. There will be a charge for any additional requests.

## Patient Authorization for Use/Release of Health Care Information

I request and authorize **Mack and Poole Pediatrics, PLC** to release health care information on the following patient(s) to:

Name: _____
(Name of individual or entity to receive this information)
Address: _____
City, State: _____ Zip:_____

**Patient Name: _____ Date of Birth: _____**
_____ _____
_____ _____
_____ _____

This request and authorization applies to:

_____ All health care information (Including all mental health records)
_____ Moving: New address _____
_____
_____ All Immunization Dates & Growth Charts
_____ Health care information relating to the following treatment, condition, or date of treatment:
_____
_____ Other _____

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_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Print Name of Patient or Legal Guardian Relationship to Patient

**THIS AUTHORIZATION **EXPIRES 60 DAYS** FROM DATE OF SIGNED REQUEST.**