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Lincoln Pediatric Associates, Inc.

www.lincolnpedi.com

AUTHORIZATION TO RELEASE/OBTAIN HEALTHCARE INFORMATION

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

I request and authorize _____

To release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Reason for Transfer:

☐ Location: _____

☐ Office Concern: _____

☐ Other: _____

May we call you to discuss your concern? YES / NO Telephone: ( ) - _____ - _____

This request and authorization apply specifically to:

☐ All healthcare information

☐ Healthcare information relating to the following treatments, condition, or dates: _____

_____

☐ Other: _____

☐ Please exclude the following Healthcare Information:
- ☐ Mental Health related information
- ☐ Substance Abuse related information
- ☐ HIV/AIDS Related information
- ☐ Other: _____

Signature of guardian if patient is under the age of 18: _____ **Date:** _____

Signature of patient if the patient is age 18 or older: _____ **Date:** _____

Please note
This authorization expires 90 days after it is signed. Please be advised that a $15 photocopying fee may apply.