Authorization for Release of Medical Information

Patient Name: _____ DOB: ____/____/_____

I, _____ hereby authorize the release of medical
(patient's name)
information **TO:**

Doctor/Clinic/Hospital: **Fairhaven Pediatrics, Inc.**

Address: **1100 Larrabee Ave Ste 100 Bellingham, WA 98225**

Telephone: **(360) 685-1225**
Fax : **(360) 282-1025**

FROM:
Doctor/Clinic/Hospital: _____

Address: _____

_____

Telephone: _____ Fax : _____

Please release the following:

_X_ **All health information (including growth charts and vaccination records, communicable diseases, mental health diagnosis and treatment)**

___ I consent to the release of information related to HIV/AIDS or infection with any other communicable diseases and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records

Purpose of disclosure:
___ Treatment/ Continuing medical care

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Signature of Parent or Legal Guardian: _____ Date: ____/____/____

Print Name: _____ Relationship to Patient: _____