John Feerick, M.D.
C. Allan Pratt, M.D.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Full Name:_______________________________________ DOB:___________________________

Parent's/Guardian's Name: __________________________________

Address: ____ Phone Number:________________________

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I authorize Tucson Children's Gastroenterology, PC to release my child's medial record in entirety to myself for the purposes of establishing personal records or ongoing medical care. I understand that these records will be provided in an electronic format and that I am responsible for passing these records on to future healthcare providers as needed. I also acknowledge that the information to be release MAY INCLUDE material that is protected by Federal Law including Drug or alcohol use or abuse, Mental Health records or testing and results of sexually transmitted infections including HIV. This consent is specifically for information created from services provided before the date of my signature. It is understood that Tucson Children's Gastroenterology will provide me with one copy, free of charge, of my child's medical record and it is up to me to make additional copies as needed. If not previously revoked, this release will expire 90 days after the date of my signature.

By my signature I testify that I am the above named child's legal guardian and have full legal rights to the information in his or her medical record.

Name (printed): ___________________________________ Relationship to patient: ____________________

Signature: _______________________________________ Date: ___________________________________

Release records to: ☐ address above or _______________________________________

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