Pavilion Pediatric Center, LLC

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RELEASE OF MEDICAL RECORDS TO PAVILION PEDIATRIC CENTER:

****IMMEDIATE:** Please fax immunization records to (765) 587-4456****

Please mail full records to:
Pavilion Pediatric Center
2525 W University Ave, Suite 404
Muncie, IN 47303
OR Fax to (765) 587-4456

Notes: ____

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Patient Information:

Patient Name: ____ DOB: ____/____/_____

Release records FROM (doctor or facility name): _______________________________________

Address: ____ City/State/Zip ________________

*Phone: (____)_____-________ Fax: (____)_____-________

Information to be released:

____ Complete Medical Record
____ Immunization Records
____ Specific Dates of Service:
From: _____/_____/______ To: ____/_____/_____
____ Other: ______________________________

I UNDERSTAND (1) I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN BASED UPON IT, (2) THAT THIS AUTHORIZATION WILL EXPIRE **60 DAYS** FROM THE DATE SIGNED, UNLESS I SPECIFY OTHERWISE, (3) THAT THE RECIPIENT OF THESE RECORDS MAY FURTHER DISCLOSE INFORMATION BECAUSE OF THIS AUTHORIZATION AND THEN IT MAY NO LONGER BE PROTECTED BY THE FEDERAL PRIVACY REGULATIONS, AND THAT PAVILION PEDIATRIC CENTER, LLC WOULD NOT BE RESPONSIBLE FOR THIS ACTION, AND (4) I AM ENTITLED TO ASK FOR AND RECEIVE A COPY OF THIS DOCUMENT.

______________________________________ ______________________________

Parent/Legal Guardian Signature Date (*mm/dd/yyyy*)

______________________________________ ______________________________

Patient's Signature **(If over 18 years old)** Relationship to Patient