

Pavilion Pediatric Center, LLC



Phone: (765) 231-9494 Fax: (765) 587-4456

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: _____

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

Specific Dates of Service: _____

____ Immunization Records

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