KJ Kids
Kjartan D. Armann, MD
Alison Chase, DO
Infant, Child and Adolescent Medicine

2516 Samaritan Dr, Suite J
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Phone: (408) 356-0578
Fax (408) 356-3986
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AUTHORIZATION TO RELEASE MEDICAL RECORD

PATIENT INFORMATION

Patient Name _____ Acct # _____

Birth date _____Daytime Telephone _____

Address _____

Street City Sate Zip Code

I authorize the following organization to release information as state below from the patient health information record.

INFORMATION TO BE RELEASED FROM:

Organization/Person Name: _____

Address _____

Street City Sate Zip Code

Phone Number: _____ Fax Number: _____

INFORMATION TO BE RELEASED TO:

Organization/Person Name: _____

Address _____

Street City Sate Zip Code

Phone Number: _____ Fax Number: _____

TYPE OF INFORMATION TO BE RELEASED

1. GENERAL RELEASE

Type of Record

☐ *Medical Record, Excluding Protected Record (This will be limited to 2yrs of information including x-ray and lab report, unless otherwise stated)* _____ *to* _____

☐ *Lab Result* _____ *to* _____

☐ *X-Ray Result* _____ *to* _____

☐ *Other Record* _____ *to* _____

2. INFORMATION PROTECTED BY STETE/FEDERAL LAW

☐ *Drug Abuse Diagnosis/Treatment* _____ *to* _____

☐ *Alcoholism Diagnosis/Treatment* _____ *to* _____

☐ *Mental Health Diagnosis/Treatment* _____ *to* _____

☐ *Sexually Transmitted Disease Diagnosis/ Treatment or Counseling (AIDS/HIV)* _____ *to* _____

PATIENT AUTHORIZATION TO RELEASE MEDICAL IMFORMATION

Date Signature of Patient or Legal Guardian Relationship to Patient

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RECORDS RELEASE FORM

Please complete the attached Record Release Form and return it with cash, money order or complete the credit card charge authorization section (NO CHECKS WILL BE ACCEPTED) for payment in the amount $25 for each record requested. Upon receipt of this completed form and your $25 payment/payments, records will be copied and released as requested.

Credit Card Charge Authorization:

Type of Credit Card (**Visa, MasterCard, Discover**)

Name as Appears on Credit Card: _____

Credit Card Number: _____

3 Digit Security Code on back of card: _____

Expiration Date (month and year): _____

Zip Code: _____

Home Address: _____

Authorized Signature: _____