AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name ________________________ Date of Birth _________________

I authorize Pamela Carlton, MD, Inc to release my (my child's) confidential medical information as indicated by the checkmark(s) below to:

____
Provider or Facility

☐ Complete Record ☐ Email communications

☐ Oral communications ☐ Other: ______________________________

☐ Records of care limited to dates below:
From: ______________ To: ______________

I also authorize Pamela Carlton, MD, Inc to release any mental health, psychological, or psychiatric records to the provider or facility indicated above.

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to HIV or infection with any other causative agent of AIDS with the rest of my medical records.

Initials ________ Date _________

☐ By checking this box I agree to make this release reciprocal. That means that the provider or facility listed above may release medical information in written, oral and/or email form to Pamela Carlton, MD.

Signed: ____ Date: ___________
Patient

Signed: ____ Date: ___________
Parent or legal guardian if patient is a minor

PAMELA CARLTON, M.D.
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