

Authorization for Release of Health Information

This form applies **only** to the release or disclosure of your health information. It is not consent for treatment and is not intended for any other purpose.

By signing this form, I authorize the release or disclosure of the protected health information (PHI) described below

To Name: _____ **From** Name: _____
Address: _____ Address: _____

If you would like to pick up PHI, we require at least one week’s notice, and there is a \$10.00 fee.

Please give reason for transfer: _____

NOTE: This authorization expires upon fulfillment of request. Information will not be resent without another signed authorization.

Patient’s Full Name (Printed) _____

DOB _____

******Our office does require at least one week’s notice to copy medical records. Thank You for your cooperation.**

I authorize the following information to be sent to the address above:

____ Copies of all records for the period
____ Copies of the information described below
____ Problem list & Vaccine Record
____ History & Physical Examination
____ X-ray reports
____ Lab reports
____ Other (Please Specify) _____

From _____ / _____ / _____
Month Day Year

To _____ / _____ / _____
Month Day Year

I understand that this information is of a personal medical nature and may include any history of or references to acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

The following information should not be released, even if occurring during dates above: _____

Special requirements: certified mail, extended expiration date, and the like: _____

I have been provided a copy of Children’s Medicine’s *Notice of Privacy Practices* and am aware that there are charges for copies of records made pursuant to this authorization. I have discussed any concerns I may have about the release or disclosure of my health information with Children’s Medicine’s Privacy Officer or the appropriate office personnel.

I understand that Children’s Medicine assumes no responsibility for the subsequent use/misuse by others of my health information which was disclosed under this authorization. I release Children’s Medicine from all legal liability that may arise from release of my information under this authorization.

Signature _____ **Date** _____
(Parent or legal guardian)

The patient or their representative may revoke this authorization by notifying in writing Children’s Medicine’s designated Privacy Officer. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Federal law also requires a statement that there is the potential that the protected health information released under this authorization may be subject to re-disclosure by the recipient. Any such re-disclosure is beyond the control of Children’s Medicine P.C.

FOR OFFICE USE ONLY

Prepared by: _____
(Staff Member Signature)

Date sent out: _____