

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____ SSN: _____

_____ Telephone: _____

Information is to be released by:

Information is to be sent to:

Physician or Facility

Physician or Facility

Street Address

Street Address

City, State, and Zip Code

City, State, and Zip Code

Telephone

Fax

Telephone

Fax

Information To Be Released – Covering the Periods of Health Care

From (date) _____ to (date) _____

Information to be released (please check):

____ complete health record ____ laboratory reports ____ x-ray reports ____ billing record

____ other (specify) _____

Purpose of Request (please check):

_____ changing physicians ____ continued care (seeing specialist) ____ copy for own use

Other (specify) _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatments and/or other sensitive information, I agree to its release. **Check One:** _____Yes _____No

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this Authorization, you have the right to revoke this Authorization by submitting a notice in writing to Fenton Pediatrics, to whom you are authorizing disclosure. Unless revoked, this Authorization will expire on the following date or event _____, or 90 days from the date of signature unless otherwise specified.

Re-release

I understand the information released pursuant to this authorization may be subject to re-release by the recipient and not longer protected by the Health Insurance Portability and Accountability Act of 1996. The practice, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient, Parent of Minor Child or Personal Representative Who May Request Disclosure

Your provider will not deny treatment if you do not sign this form. You may inspect or copy your protected health information (payment would be required for copying). By signing below, you authorize your provider, identified above, to release your protected health information specified above.

Printed Patient's Name

Signature of Patient _____ Date _____

Or

Signature of Parent _____ Date _____

Or

Signature of Representative _____ Date _____