AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

NOTE: Complete One Form Per Patient

PATIENT INFORMATION:

Name _____ Date of Birth _____

Street Address _____

Email Address _____ Phone Number _____

RELEASE MEDICAL RECORDS FROM:

Name _____

Phone Number _____

Street Address _____

Email Address / Fax Number _____

RELEASE MEDICAL RECORD TO:

Name _____

Phone Number _____

Street Address _____

Email Address / Fax Number _____

DATES OF SERVICE: (REQUIRED) _____/_____/_____ To _____/_____/_____

MEDICAL RECORDS TO BE RELEASED: (REQUIRED - Check Items Below)

☐ Office Visits- i.e. progress notes, medication list, medical history ☐ Echoes- i.e. cardiology

☐ Laboratory Reports- i.e. bloodwork, cultures ☐ Immunization Records ☐ Referral- specialists

☐ Radiology Reports- i.e. x-rays ☐ Growth Charts ☐ Itemized Bills

☐ Other (please specify): _____

☐Reproductive Health Care- i.e. contraception, preconception care, pregnancy, abortions. **PLEASE NOTE:** This authorization does not permit the release of **reproductive health care records**. Under HIPAA Privacy Rule regulation, a separate Attestation Regarding a Requested Use and Disclosure of Protected Health Information Related to Reproductive Health Care Form is required to release such records. Click this link to obtain a copy of the attestation form for your completion.

(REQUIRED) ☐ I DO ☐ I DO NOT authorize the release of information related to AIDS (acquired immunodeficiency syndrome) or HIV (human immunodeficiency virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse (INITIALS): _____

PURPOSE OF RELEASE: (REQUIRED)

☐ Personal Copy ☐ Disability Determination ☐ Insurance Purposes ☐ Legal Matter

☐ Transfer of Care (Specify Reason): ☐ Moved ☐ Insurance Change ☐ Graduated to Adult PCP

☐ Other (Please explain): _____

SIGNATURE OF LEGAL REPRESENTATIVE OR PATIENT (IF PATIENT IS 18 YEARS OR OLDER):

I acknowledge I am a legal representative, or an authorized person of the patient listed above. By signing below, I am authorizing the release and disclosure of the patient's protected health information. This authorization is valid 12 months from the date of signature. I understand that I may cancel this request with written notification, and it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized to be furnished may not condition its treatment of me on whether I sign the authorization.

Signature of Legal Representative/Patient 18yrs or older _____ Date _____

Print Name of Legal Representative/Patient 18yrs or older _____ Relationship to Patient _____