

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

Name

Phone Number

Phone Number

Street Address

Street Address

Email Address / Fax Number

Email Address / Fax Number

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

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

- | | |
|---|--|
| <input type="checkbox"/> Office Visits- i.e. progress notes, medication list, medical history | <input type="checkbox"/> Echoes- i.e. cardiology |
| <input type="checkbox"/> Laboratory Reports- i.e. bloodwork, cultures | <input type="checkbox"/> Immunization Records <input type="checkbox"/> Referral- specialists |
| <input type="checkbox"/> Radiology Reports- i.e. x-rays | <input type="checkbox"/> Growth Charts <input type="checkbox"/> Itemized Bills |
| <input type="checkbox"/> 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)

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Personal Copy | <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Insurance Purposes | <input type="checkbox"/> Legal Matter |
| <input type="checkbox"/> Transfer of Care (Specify Reason): | <input type="checkbox"/> Moved | <input type="checkbox"/> Insurance Change | <input type="checkbox"/> Graduated to Adult PCP |
| <input type="checkbox"/> 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