Authorization to Release Protected Health Information (PHI)

RM Pediatrics

Patient Name_____ Date of Birth_____ Phone:_____
Address_____City/State/Zip_____ Email Address: _____
_____ Parent Name: _____Parent Phone: _____

A) I hereby authorize records FROM:

Name_____

Address_____

City/State/Zip_____

Phone#_____

Fax#_____

B) To be released TO:

Name_____
Address_____
City/State/Zip_____ Email: _____
Fax#_____

Date Range_____to_____

- Office Notes
- Immunizations
- Other _____
- Cardiology/EKG Reports
- Lab Reports

C) For the purpose of:

_____ Litigation _____ Insurance _____ Self/Personal Copy _____ Consultation/Specialist

_____ Disability/SSI

_____ Work Comp

_____ Other

_____ Transfer of Care (Permanently Leaving)

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re- disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in the patient medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____

_____****Subject to Fees** (Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

This authorization will expire one year from the above date unless I specify an expiration date: _____ (Expiration date of authorization)