Twelve Oaks Pediatrics

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(Not for Psychotherapy Notes)

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: ____ Zip: _____

Cell Phone: _____ Home Phone: _____

RECORDS MAY BE RELEASED FROM:

I authorize _____
(Healthcare Facility/Physician) (Phone)
to release information contained in my medical record (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment and information about mental health services).

RECORDS MAY BE RELEASED TO:

Physician/Facility/Other: _____

Address: _____

Phone: _____ Fax: _____

INFORMATION TO BE DISCLOSED:

☐ All Records ☐ History and Physical ☐ Progress Notes ☐ Labs
☐ X-Ray Reports ☐ Consult ☐ Discharge Summary ☐ Other (Specify)
Specific Dates of Treatment: _____ _____

PURPOSE AND NEED FOR SUCH DISCLOSURE:

☐ Attorney/Legal ☐ Insurance ☐ Continued Patient Care ☐ Other (Specify) _____
(For health records pertaining to HIV infection or AIDS, the patient/patient representative must describe how the information to be disclosed is relevant to the purpose and need for such disclosure)

I understand that I have the 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 Privacy Officer, Twelve Oaks Pediatrics. We may have already released the information based on your original authorization. We will not release any additional information after we received your revocation. We will not condition treatment or payment based on this authorization or revocation of this authorization unless otherwise allowed by law. Your protected health information will be disclosed as specified in this authorization. This authorization will expire 120 days from the date of this signature, or when we have completed the disclosure(s) you have requested, whichever is shorter. This information could be subject to re-disclosure by the recipient and may no longer be protected.

_____ _____
Signature of Patient/Parent/Patient Representative Date

If you are signing as a Parent, Guardian, or Patient Representative, describe this relationship below.

_____ _____
Print Name Relationship to Patient

***** Fees for Copies: Federal and State Laws permit a fee to be charged for the copying of patient records *****