Partners in Pediatrics & FAMILY HEALTH

"no such thing as a dumb question"

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## Authorization for Release of Patient Identifiable Health Information

Date of Request: _____

**I, _____ hereby authorize Partners in Pediatrics and Family Health**

**_____ To release to** **_____To obtain from**

_____

**Name of Physician, Hospital, Insurance Company, Self, Etc.**

_____

**Address, P.O.BOX, City, State, Zip Code**

The following information will be released from the Medical Records of:

_____ _____ _____

Patient Name D.O. B Social Security number

Specific Information to be disclosed: ____ Entire Medical Records ____ Immunization Records

**____ Other**

***This health information is needed for: ___ School ___ Personal Use ___ Continuing Medical Care**

**___ Leaving the Practice ___ Legal Reasons ___ Military ___ Soc. Security Disability ___ Other**

- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immuno-deficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about history, diagnosis and/or treatment of drug or alcohol abuse, mental illness, or communicable disease. I authorize the disclosure of specific information.
- I also understand that the person giving authorization by written and dated notice to the Medical Record Department may revoke this authorization.
- I understand that this revocation will not apply to information that has already been released in response to this authorization.
- I understand 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. This authorization expires one year from the date of signature, unless I specify otherwise or revoke it,
- I understand I may be charged for copies of my healthcare information.
- I understand that once the above information is disclosed, it may be re-disclosed by the recipient and federal privacy laws or regulations may not protect the information.
- I understand authorizing the use or disclosure of the health information identified above is voluntary. I need not sign this to ensure healthcare treatment.

Patient's Signature: _____ Date: _____

Parent/Guardian's Signature (for Minors) _____ Date: _____

*There is a $30 charge for a copy of each complete medical record for those transferring from this office.*
This document is **valid for only one year** from the date of signature.