PH: (256) 997-5900

FAX: (256) 997-5995

Fort Payne Pediatrics

Authorization to Release Protected Health Information

Patient Name (Last)	(First)	(MI)
Date of Birth	Social Security Number	
Street Address	State	Zip

☐ I, the undersigned, do hereby authorize Fort Payne Pediatrics LLC to **receive** the above-named patient's PHI **FROM**:

☐ I, the undersigned, do hereby authorize Fort Payne Pediatrics LLC to **release** the above named patient's PHI **TO**:

(Agency/Facility/Person)

(Street Address) (City/State) (Zip)

(Phone Number) (Fax Number)

Reason for transfer or release of PHI:

☐ Insurance Change ☐ Transfer of Care ☐ Legal

☐ Moving out of area ☐ Specialty Consultation ☐ Personal

Specific PHI to be transferred or released:

☐ Entire Medical Record ☐ Other: _____

I understand that the patient's entire medical treatment record, including information pertaining to drug or alcohol abuse and psychological or psychiatric treatment, will be provided unless I specify that the following information should NOT be released:

Specific information NOT to be released

Signature

✱There is a fee to release medical records to a legal parent or guardian. Per state law, you may be charged up to $1.00 for each page of the first 25 pages, $0.50 for each page in excess of 25 pages, and a search fee of $5.00 for each patient health record requested.✱

Release or transfer of the specified information to any person or entity not specified above is prohibited. I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and mail my written revocation by certified mail, return receipt requested to the Privacy Officer at Fort Payne Pediatrics. I understand the revocation will not apply to information that has already been released in response to this authorization. I also 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. I understand that once this health care information is released, redisclosure of it by the recipient may no longer be protected by law.

This authorization is valid until _____ or two years from the date signed. Only the records from the facility/agency/person listed above can legally be released. Any record from another physician must be obtained from them.

I understand I have a right to receive a copy of this request.

Patient/Parent/Legal Guardian Signature Relationship to Patient Date

I attest to the identity of the above signature(s):

(Print) Witness Name Witness Signature Date

If age 14 or older, patient should sign this form.