PARTNERS IN PEDIATRICS

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient: _____ Address: _____

Date of Birth: _____ _____

SSN: _____ Telephone: _____

Release Records **To**: Obtain Records **From:**

_____ _____

_____ _____

□ **I give permission for records to be transferred via encrypted email (when available)**

The Purpose for this Release of Information is:

□ Personal Use □ Transfer of Care □ Insurance □ School □ Legal □ Other: _____

Information to be Released:

□ Entire Record □ or Dates of Service: _____

or Specifically: □ Problem List □ Immunizations Record □ Last History and Physical

□ Medication List □ Other □ Consultation Reports

(This Authorization includes allowing the transfer of information regarding: AIDS, HIV, psychiatric disorders, and history of treatment for drug or alcohol abuse.)

Do you authorize the release of these records as well? □ Yes □ No

I understand that this authorization may be revoked at any time, in writing, and this authorization will expire in 90 days from the date below.

Signed: _____ Printed Name: _____ Date: _____
Patient/Legal Guardian

Relationship: _____

*This authorization does not allow an agency receiving records from further distributing them without additional written consent of the patient.
*A record request from must be signed by a parent, legal guardian, or the patient (if over 18). Allow 2 or more weeks for processing. There is a $15 fee, due at the time of request, and may be paid via cash, debit, or credit card in person or over the phone.