NORTHSIDE PEDIATRICS, P.C.

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MEDICAL RECORD RELEASE

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

______________________________ Patient's Name (Last, First, Middle)   ______________ Date of Birth

By signing this authorization, I authorize the below named to use and/ or disclose certain protected health information (PHI) and individually identifiable health information (IIHI).

I hereby authorize:

______________________________ Name of Facility/ Provider/ Organization

______________________________ Address

______________________________ City   State   Zip

______________________________ Phone #   Fax#

To release information to:

______________________________ Name of Facility/ Provider/ Organization

______________________________ Address

______________________________ City   State   Zip

______________________________ Phone #   Fax#

Specific dates and/ or type of information to be disclosed:

Dates to be disclosed

______Entire History

______Limit release to dates listed: Begin Date: ______________ End Date: ____________

Information to be disclosed

______Entire Chart   ______Lab Results

______Progress Notes   ______Radiological Reports

______Other:______________________________

My initials below specifically indicates authorization for the release of the following information:

______Drug and/ or alcohol abuse and/ or treatment

______Mental health diagnosis and/ or treatment (excluding ADD/ ADHD)

______HIV/ AIDS testing, diagnosis and/ or treatment

This release of information is for the following purpose:

______Change of Physician   ______Other:______________________________

I understand that this release is effective for sixty (60) days from the date of execution and will only authorize release of records prior to date of signature. However, it may be revoked by me at any time by providing written notice to the above party.
I authorize this information to be sent via a facsimile (fax) transmission at the discretion of doctor/ facility.

The Physician, facility, and their employee's are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. I understand there is a possibility the information may be disclosed by the recipient and no longer protected under the federal privacy rules. I understand this is an optional form and my refusal to sign will not affect my ability to obtain treatment and I may obtain a photocopy of this form on request.

______________________________ Patient/ Legal Representative Signature   Relationship to Patient   Date

______________________________ Printed name of patient/ legal representative   Witness   Date

Medical
release
form