NORTHSIDE PEDIATRICS, P.C.

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MEDICAL RECORD RELEASE

PATIENT AUTHOIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____ _____

Patients 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:

_____ Entire History

_____ Limit release to dates listed Date from_____ Date to_____

Information to be disclosed:

_____ Entire Chart _____ Labe Results _____ Progress Reports

_____ 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

_____HIV/AIDS testing, diagnosis and/or treatment

This release of information is for the following purpose:

_____Change of Physician _____Referral _____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 or mailed at the discretion of the doctor/facility. I understand this is an optional form and my refusal to sign it will not affect my ability to obtain treatment and I may obtain a copy of this form on request.

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.

_____

Patient/Legal Representative Signature Relationship to patient Date

_____

Printed name of patient/Legal Representative Witness Date