Redmont Pediatric Associates, P.C.

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Medical Records Release Form

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

Please Release the following: (Check Only One)

_____ All Records _____ Immunization Records _____ Records Dated from _____ to _____

Include sensitive records: (Circle One) **Yes / No** (i.e. Psychological or Psychiatric Records, Sexually Transmitted Diseases, Pregnancy Tests, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), Hepatitis, Drug or Alcohol Abuse)

Purpose of the Release:

_____ Continuity of Treatment _____ Change of Physician

_____ Other (Please Specify Reason): _____

I wish to: (Check One)

_____ Pick up records myself _____ Have records mailed _____ Have records faxed to _____

The information may be released by: _____

(Name of Practice, Facility or Physician)

The Information may be released to: _____

(Individual, Practice of Facility receiving info)

_____

(Street Address)

_____

(City, State, Zip)

I understand the information released will be limited to information necessary to fulfill the need or purpose for the disclosure. If I have authorized the disclosure of information to a recipient who is not subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), then the recipient may re-disclose the information and it may no longer be protected under HIPPA, a federal privacy law. This authorization is valid for ninety (90) days from the date signed unless otherwise noted. This Authorization only applies to treatment occurring before the date of the signature. I may decline to sign this Authorization. I understand that I may revoke this authorization in writing at any time by completing a form available from Redmont Pediatric Associates, P.C. If I revoke this authorization, the revocation will not apply to information that has already been released to this authorization. I understand that the patient's health care and payment for the patient's health care will not be affected if I do not sign this form. I understand that I may see and copy the information described on this form if I ask for it and I may receive a copy of this form after I sign it. I may be charged reasonable copy fees as indicated under state law for my request. I represent that I have the authority and voluntary grant permission for the information to be released as described above.

Full Name: _____ Phone Number: _____

Address: _____ City, State, Zip: _____

Signature of Parent _____ (If under age 14 must be signed by parent or guardian)

Signature of Patient _____ (Patient age 14 and above)