REDMONT PEDIATRIC ASSOCIATES, P.C.
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Medical Records Release

Today's Date: _____ Patient's Name: _____

Date of Birth: _____ Social Security Number: _____

Please release the following: *(Check only one)*

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

Include sensitive records: *(Circle one)* Yes / No (ie. 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 on Line Below)

_____

I wish to: *(Check only one)*

_____Pick Records Up Myself _____Have Records Mailed

The information may be released by: _____
Name of Practice or Facility

The Information may be released to: _____
Individual, Practice or Facility receiving the information

_____
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 ("HIPAA"), then the recipient may re-disclose the information and it may no longer be protected under HIPAA, 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 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, PC. If I revoke this authorization, the revocation will not apply to information that has already been released in response to this authorization. I understand 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 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 voluntarily grant permission for the information to be released as described above.

Full Name: _____

Address: _____

City State Zip _____

Phone Numbers: Home# _____ Work# _____ Cell#_____

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

*Signature of Patient_____
(patient age 14 and up)