Kids Are Our Specialty

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name (First, MI, Last): ____________________

Address: ____________________

Phone Number: (_______) ____________________ Date of Birth: ____________________

This Release Authorization is for a Request to Transfer the following information:

☐ ***Only the following records or types of information*:** The last Well Child Check, Growth Charts, Lab Results, Immunizations, and last Chronic Care Visit (If applicable, i.e. ADHD, Asthma, etc.).

---- OR ----

☐ ***A Summary of Care.***

Treatment Dates: From (month/day/year) _____/_____/_____ To (month/day/year) _____/_____/_____

The Information may be released as follows:

TO: **Kids R Us Pediatrics**
121 Golfview Dr. NE
Arab, AL 35016

FROM: ____________________
Phone: ____________________
Fax: ____________________

OR —

TO: ____________________
Phone: ____________________
Fax: ____________________

FROM: **Kids R Us Pediatrics**
121 Golfview Dr. NE
Arab, AL 35016

Purpose of the release:

I understand the Information released will be limited to information necessary to fulfill the need or purpose for the disclosure. I understand that this information may contain psychiatric/psychological, alcohol/drug abuse, AIDS/HIV information, and/or other sensitive health information and I expressly consent to the release of the information. 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 it and it may no longer be protected under HIPAA, a federal privacy law. This Authorization is valid for ninety (90) days from the date of signature, unless otherwise noted. This Authorization only applies to treatment occurring before the date of signature. I may decline to sign this Authorization. I understand I may revoke this authorization in writing at any time by completing a form available from Medical Information Services. 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 the 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. Before requesting medical record copies, please ask about the copy fee by law that may apply. I represent that I have the authority to and voluntarily grant permission for the Information to be released as described above.

____________________ ____________________
Patient/Parent/Legal Guardian Printed Name Parent/Legal Guardian Signature Date

____
Patient Signature if 18 or Older