Authorization to release Protected Health Information *from* Adventure Pediatrics *to* an outside provider/facility

This form is to be used only to request records from outside Adventure Pediatrics. Please print request in black ink, including address and fax number.

_____ _____/_____/_____

Patient Name: Last First MI Date of Birth

Release Information To:

Name: _____
Address: _____
_____
Phone: _____
FAX: _____

Release Information from:

Adventure Pediatrics
Medical Records

Reason for Release: _____

Release the following Health Information:

☐ Entire Medical Record ☐ Inclusive Dates Only ___/___/___ through ___/___/___

☐ Immunization Records ☐ Other _____

I hereby authorize the above facility/provider to disclose medical information concerning the above named patient to the party identified in the section titled “Release Information To”. I understand that the information to be released may include information regarding Psychological or psychiatric conditions, Drug and Alcohol usage, and AIDS/HIV related information. I understand that once this information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law my refusal to sign will not affect my ability to obtain treatment, receive payment or eligibility for benefits.

Expiration or revocation of authorization: I understand that I may revoke this authorization at any time. This authorization will expire on _____. Specify an expiration date, if blank this form will expire in one year.

Use of copies: A copy of this authorization may be utilized with the same effectiveness as an original.

Reimbursement: Adventure Pediatrics, PLLC reserves the right to recover costs involved in producing the requested information. You or the recipient of the records may be charged $20 plus 50 cents per page for handling and copying this information.

Patient Age: If the patient is 18 years of age or older, the patient must sign and date the form.

_____ _____ _____
Printed Name Date Phone number (if questions)

_____ _____
Signature Relationship to Patient