

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

ONE PER REQUEST

Patient Full Name (PRINT) _____ DOB _____

Is requesting that Carroll Children’s Center practice identified above release health information (check ONE)

TO or obtain FROM the person/company/agency/facility listed below.

Name, Position, or Department: _____
Name of Organization: _____
Address of Organization: _____
Phone # of Organization: _____ Fax: _____

The information to be disclosed relates to service dates beginning _____ and ending _____

<input type="checkbox"/> Entire Medical Record	<input type="checkbox"/> Medication List	<input type="checkbox"/> Referring Doctor Reports
<input type="checkbox"/> Demographic Information	<input type="checkbox"/> Immunizations	<input type="checkbox"/> History & Physical
<input type="checkbox"/> Test Results (lab, X-ray, etc.)	<input type="checkbox"/> Medical/Surgery History	<input type="checkbox"/> Physician Office Visits
<input type="checkbox"/> Other Assessments	<input type="checkbox"/> Other: (specify)	<input type="checkbox"/> Other: (specify)
<input type="checkbox"/> Routine Records: Last Physical Exam, Growth Chart, Shot Record, Health History (this option usually suffices when transferring to another physician)		

The purpose of the disclosure: (*“Request of the Individual” is sufficient for patient-initiated releases*)

<input type="checkbox"/> Request of Individual	<input type="checkbox"/> Change of Doctor	<input type="checkbox"/> Legal Purposes
<input type="checkbox"/> Referral to Specialist	<input type="checkbox"/> Insurance	<input type="checkbox"/> Other: (specify)
<input type="checkbox"/> Personal	<input type="checkbox"/> Continuing Care	<input type="checkbox"/> Other: (specify)

CONDITIONS and NOTIFICATIONS:

Federal Law prohibits Carroll Children’s Center from any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. This authorization will automatically expire one month from the date signed, and you may revoke this consent at any time except to the extent that action has already been taken in reliance thereon.

Note: There may be a processing fee charged to the patient (or parent) to cover labor, copying, and supplies used to reproduce medical records.

SIGNATURES:

I hereby authorize the use or disclosure of the personal health information as described above. I understand that I may refuse to sign this authorization, that this authorization is voluntary and my health care and the payment for my health care will not be affected if I do not sign this form. I also understand that if the individual or organization authorized to receive the information is not a health plan or health provider, the released information may no longer be protected by federal privacy regulations and, therefore, may be subject to re-disclosure.

Signature of Patient/Personal Representative: _____ Date: _____

PRINT name of Personal Representative: _____

Relationship of Representative to Patient: _____

Phone: _____