Authorization for Disclosure of Protected Health Information

Patient Contact Information

Name of Patient _____ Date of Birth _____

Address (City, State, Zip Code) _____

Phone _____Dates of Service _____

Reports to be Disclosed

Please indicate those reports that you would like to be disclosed.

History and Physical Exam		Growth Chart	
Consultation Reports		Operative Reports	
Progress Notes		Billing Claims Forms	
Radiology Reports		Itemized Statement of Charges	
Laboratory Reports		All Information	
Pathology Reports		Immunization Record	

Other _____

Records Released From

Name _____ Phone _____

Mailing Address _____ Fax _____

City, State, Zip Code _____

Records Released To

Name _____ Phone _____

Mailing Address _____ Fax _____

City, State, Zip Code _____

Reason for record release _____

Authorization

I authorize the third party named in the above section to disclose the protected health information about myself (or the patient) as described above. I understand:

- This authorization expires 180 days from the date of my signature unless I specify otherwise. Expiration _____
- I may revoke this authorization at any time by notifying ALICE PEDIATRIC CLINIC in writing. If I revoke the authorization, I understand that it will have no effect on actions ALICE PEDIATRIC CLINIC took in good faith before receiving the revocation.
- The information released may contain information related to AIDS or HIV infection; drug or alcohol abuse; mental or behavioral health or psychiatric care, except for psychotherapy notes.
- ALICE PEDIATRIC CLINIC may not condition treatment or payment on my completion of this form.
- ALICE PEDIATRIC CLINIC reserves the right to verify my identity or guardianship.

Signature _____ Date _____

Printed Name _____ Relationship to Patient _____

(*This completed form authorizes a third party to disclose a patient's protected health information to ALICE PEDIATRIC CLINIC*)