Patient Request for Access to Protected Health Information

Contact Information

Name of Patient ____ Date of Birth ____________________________

Address (City, State, Zip Code) ____

Phone _____________________________________ Dates of Service ___________________________________

Date Information Needed _________________________

Mail copies to:

__ Address listed above __ Address listed below

Address (City, State, Zip Code)

____

Authorization

I authorize Alice Pediatric Clinic 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.
- If the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
- 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.
- I will be charged for the copies requested.

Signature ____ Date _________________________________

Printed Name ____

Relationship to Patient ____

Reports Requested

Document Type	Fee	Requested	Document Type	Fee	Requested
Patient transfer summary (summary of chart for release to another physician)	$25.00		Affidavit	$15.00	
Immunization Record	$ 5.00		CPS Record	$0.00	
Lab Report	$ 5.00		Worker's Compensation Request	$25.00	
Growth Chart	$ 5.00		Retrieval Fee (to obtain records from storage)	$25.00	
Entire Paper Record	$25.00		Electronic Record via CD	$25.00	
Other					

Reason for Transfer

Please indicate the reason why you are transferring out of our practice.

Moving out of the city or state _______
Child is transitioning to an adult physician _______
Practice does not accept insurance _______
Dissatisfied with care _______

Alice Pediatric Clinic

October 2017

For Office Use Only: Processed by: __________________________ **Date:** _________________