**** **Medical Records** **Release Authorization**

 3683 US HWY 431

Albertville, AL 35950

 **Phone: (256) 849-0436** ■ **Fax: (256) 849-0769**

**Patient’s Information**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Middle

D.O.B.: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_

**Release of Patient Information**

**Please Select** **ONE**: □ **Obtain Records From** □ **Release Records To**

|  |
| --- |
| **Practice/Facility/Person** |
| **Phone Number** | **Fax Number** |

**Information to be Obtained or Released**: ***(Ex: Entire Medical Record, Specific Date(s) of Services, Immunization Records, etc.)***

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**Purpose for Obtaining or Releasing Information**:

□ Transfer to Another Pediatric Practice □ Personal Usage □ Moving out of Area

□ Transfer to Adult Practice □ Legal Usage □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize Kids Klinic, LLC., or the recipient listed above, to use or disclose protected health information regarding myself (if ≥ 14 years old)/my child’s care and treatment. I understand that if the patient’s medical record or billing record contains information that references drug/alcohol abuse, psychiatric care, mental health treatment, HIV/AIDS, I agree to its release unless I specify otherwise. I understand information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by the HIPAA Rules. Obtaining or releasing the specified information to any person or entity not specified above is prohibited. Only the specified information from this practice can be legally released, and any information or record from another practice or facility must be obtained directly from them.

I understand have the right to revoke this authorization in writing at any time except to the extent that the practice has acted in reliance upon this authorization. I also understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I agree to hold Kids Klinic, LLC harmless and release them from any liability for any claims or actions, which may occur as a result of the obtained/released information. I understand that this authorization will expire twelve months from the date signed, and I understand I have a right to receive a copy of this request.

 **Please Select ONE**:

□ I hereby state that I am the child’s parent or legal guardian and have the legal right to make and or restrict healthcare

 decisions regarding this child, and that my parental authority has not been terminated or restricted by the courts. I also attest

 that this child is less than 14 years old and/or is physically/mentally handicapped and not able to sign this authorization for

 himself/herself.

□ I hereby state that I am the patient listed above and I am 14 years old or older.

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 Print Name of Patient/Parent/Legal Guardian Relationship to Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

 Signature of Patient/Parent/Legal Guardian Date Signed