Anthem Hills Pediatrics

HIPAA COMPLIANT AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name _____

Date of Birth _____ Social Security Number _____

Address _____ State _____ Zip _____

I authorize the use or disclose the above named individuals' PHI to be released as follows:

_____ Medical Record _____ Xrays _____ Immunizations _____ Other

Reason for request:

_____ Continuing Care _____ Personal _____ Insurance _____ Attorney _____ Other

Transfer Records From:

Name _____

Address _____ State _____ Zip _____

Phone _____ Fax _____

Transfer Records To:

Name _____

Address _____ State _____ Zip _____

Phone _____ Fax _____

There is a fee to release medical records to a legal parent or guardian. If a hard copy is requested it is .60 per page. If records are scanned to a disk it is $10.00.

I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its' purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it certified mail, return receipt requested to the Privacy Officer at the health care provider listed above. Information used to disclose pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.

This authorization is valid for _____days or one year from the date signed. Only the records from this facility can legally be released. Any record from another physician must be obtained from them.

_____ _____

Signature Patient/Guardian Date