Eureka
PEDIATRICS
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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Information:
Full Name:_____ **Date of Birth:**_____
Address:_____

Information to be released by:
Physician/Facility: EUREKA PEDIATRICS
Address: 515 N. VIRGINIA AVE
EUREKA MO 63025

Information to be sent to:
Physician/Facility:_____
Address:_____
Phone:_____ **Fax:**_____

Information to be released:
Complete Health Records _____ **Radiology Reports** _____ **Laboratory Results** _____
From date _____ **To date** _____

Reason for release:
New PCP_____ **Relocating**_____ **Copy for personal use**_____

I understand that if my medical record contains information in reference to drug and alcohol abuse, psychiatric care, sexually transmitted diseases, Hepatitis testing, HIV/AIDS or other sensitive information, I agree to its release. Yes_____ No_____
I understand the information released by this authorization may be subject to re-release by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996. Eureka Pediatrics, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. Yes_____ No_____
I understand that I can revoke this authorization, in writing, at any time. Unless revoked, this release will expire on 90 days. Yes_____ No_____

Signature of Patient or Legal Representative who may request disclosure:

Signature:_____ **Relationship to patient:**_____ **Date:**_____