Authorization for Release of Information

All records will be released on CD unless otherwise indicated

Please release records by: ☐ PATIENT PORTAL ☐ FAX (15 pages or less) (Fax # (____) ____-_____ ☐ PAPER (Over 15 pages)

For records 15 pages or less, FAX to: 334-702-1638

For records 16 pages or more, MAIL CD or paper to: Dothan Pediatric Clinic, 126 Clinic Drive, Dothan, AL 36303

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: _____-_____-_____ SS#: _____-_____-_____ MEDICAL RECORD #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____

I hereby authorize _____
(Print on the line above the name of the physician you authorize to release information from medical record to the individual / physician listed below):

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

INFORMATION TO BE RELEASED:

	DATES:
☐ History and Physical Exam	_____
☐ Progress Notes	_____
☐ Lab Reports	_____
☐ X-ray Reports	_____
☐ Treatment Information	_____
☐ Psychological Testing Report	_____
☐ Other: _____	_____
_____	_____

I specifically authorize the release of information relating to:
- ☐ Substance abuse (including alcohol/drug abuse
- ☐ HIV related information (AIDS related testing)
- ☐ Mental health (including psychotherapy notes)
- ☐ Sexual abuse
- ☐ Sexually Transmitted Diseases

X _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

PURPOSE OF DISCLOSURE: ☐ Changing Physicians ☐ Consultation/Second Opinion ☐ Continuing Care
☐ Legal ☐ School ☐ Insurance ☐ Worker's Compensation
☐ Other (please specify): _____

1. I understand that this authorization will expire on _____ (Print the Date this Form Expires) days after I have signed the form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal Privacy Regulations.
4. I understand that if I am being requested to release this information by _____ (Print Name of Provider) for the purpose of: _____
   a. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
   b. I understand that I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.
   c. I have been informed that _____ (Print Name of Provider) ☐ will / ☐ will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
5. I understand that in compliance with _____ (Print the State Whose Laws Govern the Provider) statute, I will pay a fee of $_____ (Print the Fee Charged). There is no charge for medical records if copies are sent to facilities for ongoing care of follow-up treatment.

_____ _____ OR _____ _____
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

_____ _____ _____
RECORDS RECEIVED BY DATE RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY
DATE REQUEST FILLED: _____ BY: _____
IDENTIFICATION PRESENTED: _____ FEE COLLECTED: $ _____