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Authorization to Use/Release/Disclose Health Information

PLEASE ALLOW 14 BUSINESS DAYS FOR ALL MEDICAL RECORDS REQUESTS.

Section A: (Must be completed for all authorizations)

I, \_\_\_\_\_, understand that Raleigh Pediatrics is authorized by me to use, release, and/or disclose the Protected Health Information (PHI) as described below. I understand the information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by the Privacy regulations.

- If this request is for any patient 18 years or older, the form must be signed by the patient.
If the patient is in the custody of the county, a representative of the county (Ex: social worker) must complete this release form. (Not the foster parent)
If the request is for records to be sent to Raleigh Pediatrics, this form is to be mailed or faxed by the parent and not from Raleigh Pediatrics.

Patient's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Best Contact #: \_\_\_\_\_
Release From: \_\_\_\_\_ Release To: \_\_\_\_\_
Name: \_\_\_\_\_ Name: \_\_\_\_\_
Address: \_\_\_\_\_ Address: \_\_\_\_\_

\*\*\*\*\* NOTE: IF MEDICAL RECORDS ARE MORE THAN 30 PAGES, PLEASE MAIL TO OUR OFFICE. \*\*\*\*\*

I authorize the following information to be sent to the above address (Check all that apply):

\_\_\_ Copy of Complete Medical Records (specify dates) Date: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_
\_\_\_ Copy of Information described below Date: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_
\_\_\_ History & Physical Exams
\_\_\_ Reports from other Physicians (Specialist)
\_\_\_ Labs, X-rays, etc. reports
\_\_\_ Other (Explain): \_\_\_\_\_
\_\_\_ The following information should NOT be released (Explain): \_\_\_\_\_

Purpose of use or disclosure:

\_\_\_ Transferring to another provider \_\_\_ Physician/Staff Request
\_\_\_ Patient/Parent Request \_\_\_ Moving - Please provide forwarding address: \_\_\_\_\_

Other (Please explain): \_\_\_\_\_

Section B: (Must be completed for ALL Authorizations)

I understand that:

- I may revoke this authorization at any time by notifying the Practice's HIPAA Privacy Officer in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively. I may request or copy the protected health information to be used or disclosed.
This authorization will expire ten years from today's date unless otherwise specified.
Raleigh Pediatric Associates assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization.

Patient/Parent/Guardian Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date \_\_\_\_\_

Office Use Only:
Patient Chart #: \_\_\_\_\_ Date Information Disclosed: \_\_\_\_\_ Initials: \_\_\_\_\_
HIPAA Review Officer (if records being inspected by patient/parent): \_\_\_\_\_ Date Reviewed: \_\_\_\_\_