

CHILDREN'S MEDICAL GROUP, P.A.

PEDIATRICS
3920 AIRPORT BOULEVARD
MOBILE, ALABAMA 36608
610 PROVIDENCE PARK DRIVE, SUITE 201
MOBILE, ALABAMA 36695

Airport (251) 342-3810
Providence (251) 639-1300

Please allow 5 – 7 days for requested records to be sent.

_____/_____/_____
Patient Name (Print) SS or Health Record Number Patient DOB

Address City/St/Zip Phone

I authorize _____ to use or release/disclose my health information as described below.
Address _____ Phone: _____ Fax: _____

Please identify the information to be released:

Please release my entire record
-OR-

- Please release *only* the following information (check appropriate boxes and include other information where indicated):
- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Problem List | <input type="checkbox"/> List of Allergies | <input type="checkbox"/> Immunization | <input type="checkbox"/> Medication List |
| <input type="checkbox"/> Office Notes _____ | <input type="checkbox"/> History & Physical _____ | <input type="checkbox"/> Discharge _____ | <input type="checkbox"/> ER _____ |
| <input type="checkbox"/> Lab results: _____ | <input type="checkbox"/> X-ray and imaging reports: _____ | | |
| <input type="checkbox"/> Consultation reports: _____ | <input type="checkbox"/> Other (please describe): _____ | | |

The identified information will be used for the following purpose: Change to another Pediatrician
 My personal records Attorney/Legal Continued Care (Consult/Referral) other _____

Please initial each item below to indicate your understanding.

- _____ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- _____ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
- _____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand 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 understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

The identified information may be used by or released to the following individual(s) or organization(s):

Name: _____
Address: _____ Phone: _____ Fax: _____

This authorization will expire on (insert date or event): _____ If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

_____/_____/_____
Patient Signature / Parent / Legal Guardian Relationship Date
_____/_____/_____
Witness Signature Date