Medical Records Release Authorization

45 Medical Park Drive, Suite B
Guntersville, AL 35976

2525 US Hwy 431, Suite 210
Boaz, AL 35957

Phone: (256) 571-8969 ■ Fax: (256) 571-8980

PATIENT'S INFORMATION

Patient's Name: _____
Last First Middle

D.O.B.: _____/_____/_____ Age: _____ Sex: _____

RELEASE OF PATIENT INFORMATION

Please Select ONE: □ **Obtain Records From** □ **Release Records To**

Practice/Facility/Person	
Phone Number	**Fax Number**

Information to be Obtained or Released: ***(Ex: Entire Medical Record, Specific Date(s) of Services, Immunization Records, etc.)***

_____

_____

Purpose for Obtaining or Releasing Information:

□ Transfer to Another Pediatric Practice □ Personal Usage □ Moving out of Area

□ Transfer to Adult Practice □ Legal Usage □ Other: _____

I hereby authorize Marshall County Pediatrics, P.C., or the recipient listed above, to use or disclose protected health information regarding myself (if ≥ 14 years old)/my child's care and treatment. I understand that if the patient's medical record or billing record contains information that references drug/alcohol abuse, psychiatric care, mental health treatment, HIV/AIDS, I agree to its release unless I specify otherwise. I understand information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by the HIPAA Rules. Obtaining or releasing the specified information to any person or entity not specified above is prohibited. Only the specified information from this practice can be legally released, and any information or record from another practice or facility must be obtained directly from them.

I understand have the right to revoke this authorization in writing at any time except to the extent that the practice has acted in reliance upon this authorization. I also understand that 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 agree to hold Marshall County Pediatrics, P.C. harmless and release them from any liability for any claims or actions, which may occur as a result of the obtained/released information. I understand that this authorization will expire twelve months from the date signed, and I understand I have a right to receive a copy of this request.

Please Select ONE:

□ I hereby state that I am the child's parent or legal guardian and have the legal right to make and or restrict healthcare decisions regarding this child, and that my parental authority has not been terminated or restricted by the courts. I also attest that this child is less than 14 years old and/or is physically/mentally handicapped and not able to sign this authorization for himself/herself.

□ I hereby state that I am the patient listed above and I am 14 years old or older.

_____ _____
Print Name of Patient/Parent/Legal Guardian Relationship to Patient

_____ _____/_____/_____
Signature of Patient/Parent/Legal Guardian Date Signed