AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

ONE PER REQUEST

Patient Full Name (PRINT)_____DOB_____

Is requesting that Carroll Children's Center practice identified above release health information (check ONE)

❑ TO or obtain ❑ FROM the person/company/agency/facility listed below.

*Name, Position, or Department:*_____

*Name of Organization:*_____

*Address of Organization:*_____

*Phone # of Organization:*_____*Fax:*_____

The information to be disclosed relates to service dates beginning _____and ending_____

❑ Entire Medical Record	❑ Medication List	❑ Referring Doctor Reports
❑ Demographic Information	❑ Immunizations	❑ History & Physical
❑ Test Results (lab, X-ray, etc.)	❑ Medical/Surgery History	❑ Physician Office Visits
❑ Other Assessments	❑ Other: (specify)	❑ Other: (specify)
❑ Routine Records: Last Physical Exam, Growth Chart, Shot Record, Health History (this option usually sufficies when transferring to another physician)		

The purpose of the disclosure: *("Request of the Individual" is sufficient for patient-initiated releases)*

❑ Request of Individual	❑ Change of Doctor	❑ Legal Purposes
❑ Referral to Specialist	❑ Insurance	❑ Other: (specify)
❑ Personal	❑ Continuing Care	❑ Other: (specify)

CONDITIONS and NOTIFICATIONS:

Federal Law prohibits Carroll Children's Center from any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. This authorization will automatically expire one month from the date signed, and you may revoke this consent at any time except to the extent that action has already been taken in reliance thereon.

Note: There may be a processing fee charged to the patient (or parent) to cover labor, copying, and supplies used to reproduce medical records.

SIGNATURES:

I hereby authorize the use or disclosure of the personal health information as described above. I understand that I may refuse to sign this authorization, that this authorization is voluntary and my health care and the payment for my health care will not be affected if I do not sign this form. I also understand that if the individual or organization authorized to receive the information is not a health plan or health provider, the released information may no longer be protected by federal privacy regulations and, therefore, may be subject to re-disclosure.

Signature of Patient/Personal Representative:_____Date:_____

PRINT name of Personal Representative:_____

Relationship of Representative to Patient:_____

Phone:_____

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