Children's of Alabama

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**PLEASE RETURN THIS FORM TO ONE OF THE FOLLOWING LOCATIONS:**

**Pediatrics East - Deerfoot**
6729 Deerfoot Parkway
Pinson, AL 35126
PHONE: (205) 681-5377
FAX: (205) 638-7102

**Pediatrics East - Trussville**
520 Simmons Dr
Trussville, Al 35173
PHONE: (205) 661-4680
FAX: (205) 638-7102

# Children's of Alabama –**Annual Form**

## Authorization to Release Information by Fax

**(Past and Future Care)**

Patient Name (First, Last, MI): _____ Date of Birth: _____

Address: _____ Contact Phone #: _(___)_____

| What information do you want to release (fax)? | Where do you want this information to be sent? (examples may be school, work) |
|---|---|
| ____ Work/School Excuse<br>____ Medication Administration Form<br>____ Sports Physical Form<br>____ Camp Form<br>____ Daycare Form<br>____ WIC Form<br><br>**Note**: This form is a limited fax release of information authorization. In order to authorize the release of information not list above you must complete Pediatrics East's standard Release of Information Form. | Please print list of locations:<br>Facility / Person Name & Fax Area code + Number<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____ |

I authorize Pediatrics East and its employees/physicians to release the information stated above. I understand this authorization is voluntary and for my own convenience. I understand Pediatrics East will release only those items indicated by me unless there is a medical emergency. The health record(s) released by Pediatrics East may possibly be re-disclosed by the facility/person that receives the record(s) and therefore (1) Pediatrics East and its employees/physicians have no responsibility or liability as a result of the re-disclosure and (2) such information would no longer be protected by the HIPAA Privacy Rule. This Authorization is in effect for a period of **one year** from the date my signature unless a shorter time frame is documented. I have the right to revoke/change my mind about this Authorization form at any time by sending a written request to the Practice Manager at the Practice Address above. My decision to revoke the Authorization does not apply to any release of my child's health record(s) that may have taken place prior to the date of my request to revoke the Authorization.

_____ _____ _____

Patient/Parent/Guardian Print Name | Patient/Parent/Guardian Signature | Date

_____ _____

Witness for Patient/Parent/Guardian | Date