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 - Authorization for Release of Information

Patient Name (First, MI, Last):_____

Address/City/State/Zip: _____

Phone Number: (____) _____**Date of Birth:** _____

This Authorization applies to the following Information:

☐ ***All*** **Information**. I understand that the information may contain psychiatric/psychological, alcohol/drug abuse, and/or AIDS/HIV information and I expressly consent to the release of the information.

☐ ***Only*** the following records or types of Information:_____

Treatment Dates: from (month/day/year) _____/_____/_____ **to** (month/day/year) _____/_____/_____

I consent for my child's medical records to go: **To:** **Practice Name: Pediatrics East** **Address: 6729 Deerfoot Parkway** **City/State/Zip : Pinson, AL 35126** **Phone: (205) 681-5377**	OR	***I consent for my child's medical records to go:*** **From:** **Practice Name: Pediatrics East** **Address: 6729 Deerfoot Parkway** **City/State/Zip : Pinson, AL 35126** **Phone: (205) 681-5377**
From: Origin Name: _____ Address:_____ City/State/Zip: _____ Phone: _____		**To:** Origin Name: _____ Address: _____ City/State/Zip: _____ Phone: _____

Purpose of the release: ☐ Continuity of Treatment ☐ Other (*Please specify*_____)

I understand the Information released will be limited to information necessary to fulfill the need or purpose for the disclosure. If I have authorized the disclosure of Information to a recipient who is not subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), then the recipient may re-disclose it and it may no longer be protected under HIPAA, a federal privacy law. This Authorization is valid for ninety (90) days from the date of signature, unless otherwise noted. This Authorization only applies to treatment occurring before the date of signature. I may decline to sign this Authorization. I understand I may revoke this authorization in writing at any time by completing a form available from Pediatrics East. If I revoke this authorization, the revocation will not apply to information that has already been released in response to this authorization. I understand the patient's health care and the payment for the patient's health care will not be affected if I do not sign this form. I understand I may see and copy the Information described on this form if I ask for it, and I may receive a copy of this form after I sign it. Before requesting medical record copies, please ask about the copy fee by law that may apply. I represent that I have the authority to and voluntarily grant permission for the Information to be released as described above.

_____ _____
Patient/Parent/Legal Guardian Printed Name Patient/Parent/Legal Guardian Signature Date

_____ _____
Patient Signature if Adult (ie.19 or older) Date Witness Signature Date