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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) 212-7102

**Pediatrics East - Trussville**  
 520 Simmons Dr  
 Trussville, Al 35173  
 PHONE: (205) 661-4680  
 FAX: (205) 212-7102

**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) \_\_\_\_/\_\_\_\_/\_\_\_\_

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

**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