*DT0063*

Children's of Alabama

**1600 7th Avenue South**
**Birmingham, AL 35233**

**PLEASE RETURN TO:**
Children's of Alabama
Medical Information Services
1600 7th Avenue South
Birmingham, Alabama 35233
Fax (205) 638-5367
Phone (205) 638-9728

# AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name (Last, First, MI):_____

Address: _____

Phone Number: (_____) _____Date of Birth: _____

This Authorization applies to the following Information:

☐ ***All** Information/Complete Medical Record*.

I understand that the information may contain psychiatric/psychological, alcohol/drug abuse, AIDS/HIV information, and/or other sensitive health 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) ____/____/_____

The Information may be released as follows:

☐ From Children's of Alabama
1600 7th Avenue South
Birmingham, AL .35233

To _____
_____
_____

OR ----------

☐ From _____
_____
_____

To Children's of Alabama
1600 7th Avenue South
Birmingham, AL .35233

_____

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 Medical Information Services. 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 Parent/Legal Guardian Signature Date

_____ _____
Patient Signature if 19 or older Date Witness Signature for Patient/Parent/ Legal Guardian Date

Children's of Alabama
1600 7th Avenue South
Birmingham, AL 35233

# Release of Information Guidelines

## What You Need to Know About Requesting Copies of Medical Records

**THIS FORM MUST BE RETURNED WITH THE AUTHORIZATION**

1. The authorization must be:
   a. Completed in full
   b. Completed in black or blue ink
   c. Addressed to Children's Hospital of Alabama
   d. Signed by the patient if:
      i. The patient's age today is 19 years or older **– OR –**
      ii. The patient is an Emancipated Minor (married, divorced or born a child)
         1. Females under the age of 19 years who are pregnant or who have borne a child can authorize the release of medical records of their child.
   e. Signed by either of the patient's parents or the patient's legal guardian if the patient is under the age of 19 years. A copy of the parent's driver's license is required. ** *If the requesting parent's name is not in the child's record, a copy of the birth certificate must be presented to establish parental relationship.***
   f. In the case of **Alabama MEDICAID patients**, written permission from the Alabama Medicaid Agency to release the patient's medical records for reasons other than continued care must be attached to the authorization.
      i. It is the patient/parent/legal guardian/legal representative's responsibility to contact:
      ii. Health Management Services
      Attn AL Case Management Unit
      5615 High Point Drive Suite 100
      Irving, TX 75038
      Toll Free Phone 1-877-252-8949
      iii. A copy of the letter received from Alabama Medicaid must be attached to the authorization.
   g. Mailed to:
      Healthport
      c/o Children's Hospital of Alabama
      Medical Information Services
      1600 7th Avenue South
      Birmingham, AL 35233

2. As allowed by Federal and State regulations, reproductions fees for copies of medical records may be required as applicable; an invoice will accompany the copies of medical records.
   a. Based upon Alabama Regulations, the current reproduction fees are as follows:
      i. $5.00 search/retrieval fee per request
      ii. $1.00 per page 1 to 25 pages
      iii. $0.50 per page 26+ pages
      iv. Actual Postage
      ***Patient's are not charged a search/retrieval fee.**
   b. No charge is made for continued care requests received from other health care providers (hospitals, physician offices, clinics, etc.)
   c. **The copy fees are higher for producing microfilmed records.**

3. Upon Receipt of a completed, valid authorization, copies of medical records may be expected within 7-10 days.
      i. Questions or follow-up calls regarding the status of requests may be directed to Children's Hospital of Alabama, Release of Information staff at 205-638-9728.

By signing this form I acknowledge that I have read the above and have no further questions about the information listed.

_____ _____
Printed Name Date Signature

How may we contact you?

Telephone: Home_____ Work_____

Cellular _____ Other _____