AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME:	DATE OF BIRTH:
ADDRESS:	PHONE NUMBER:

INFORMATION TO BE RELEASED: ___ MAIL ___ PICK-UP ___ FAX ___ OTHER:	FROM:	TO: COUNTRY KIDS PEDIATRICS 1815 10TH STREET FLORESVILLE, TX 78114

PLEASE CHECK TYPE OF INFORMATION TO BE RELEASED:

___ ALL RECORDS LAST 2 YEARS ___ ALL RECORDS LAST ____ YEARS ___ X-RAY REPORTS

___ PROGRESS NOTES ONLY ___ CONSULTATION REPORTS ONLY

___ LABORATORY TEST RESULTS ONLY ___ IMMUNIZATIONS/GROWTH CHARTS

PURPOSE OF REQUEST:

___ CHANGE OF PHYSICIAN ___ RELOCATION/MOVING ___ BILLING/CLAIMS

___ REFERRAL APPOINTMENT ___ SCHOOL/DAYCARE REGISTRATION

___ OTHER (SPECIFY):

DRUG, ALCOHOL, PSYCHIATRIC, AND HIV/AIDS INFORMATION:

I understand that the requested information may contain reference to or results of HIV/AIDS testing and/or treatment drug abuse, alcohol abuse, psychiatric care, sexually transmitted diseases, Hepatitis B/C testing, and or other sensitive information. I authorize the release of such confidential information to the indicated party, unless prohibited in my instructions above.

TIME LIMIT AND RIGHT TO REVOKE AUTHORIZATION:

I understand that I can at any time revoke this authorization in writing. I am fully aware that any action prior to this receipt of this revocation, is in reliance with this original authorization. I will submit my notice in writing to Country Kids Pediatrics, 1815 10th Street, Floresville, TX 78114.

RE-DISCLOSURE STATEMENT:

I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPPAA of 1996. The facility, its employees, representatives, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

FEE FOR COPYING REQUESTED INFORMATION:

I understand that there will be a fee associated with the copying of the requested information. I have been notified of this policy and agree to pay accordingly. The fee is $25 for the first 20 pages and 50 cents for each additional page per medical record request.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE WHO MAY REQUEST DISCLOSURE:

I understand that I do not have to sign this authorization. My treatment or payment for services will not be denied if I do not sign form, unless specified above under the Purpose of Request. I can view or receive a copy of the Protected Health Information (PHI) to be used or disclosed. I authorize Country Kids Pediatrics to use and disclose the PHI specified above.

PRINT PATIENT/PARENT NAME: _____ DATE: _____

PATIENT/PARENT SIGNATURE: _____

WITNESS PRINT NAME: _____ DATE: _____

WITNESS SIGNATURE: _____