AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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PHONE NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT PHYSICIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE RANGE OF FILES TO BE RELEASED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize **FOXHALL PEDIATRICS** to release/disclose my health information as described below:

\_\_\_\_ Please release my entire medical record OR

\_\_\_\_ Please release **only**the following information (Check all that applies)

 \_\_\_\_ History & Physicals/ Progress Notes

 \_\_\_\_ Immunization Record/Growth Charts

 \_\_\_\_ Lab/ Radiology Reports

 \_\_\_\_ Consultation Reports

 \_\_\_\_ Allergies

Please initial each item to indicate your understanding.

\_\_\_\_ I understand the information in my health record may include information relating to sexually transmitted diseases, behavioral / mental health services, and treatment for alcohol and drug abuse.

\_\_\_\_ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected be federal privacy laws or regulations.

\_\_\_\_ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health treatment.

**\*ALL RECORDS MUST BE PICKED UP AT OUR OFFICE**

**\*PLEASE KEEP IN MIND THERE WILL BE A FEE DEPENDING ON THE SIZE OF THE CHART. PAYABLE AT THE TIME RECORDS ARE PICKED UP**

I understand that I may revoke this authorization by sending a letter to FOXHALL PEDIATRICS at the address listed above. By signing I certify that I have read and agreed to the PHI