ST. ROSE
PEDIATRICS

Authorization For Release of Medical Information

Patient Name:_____DOB:_____

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 [45 C.F.R 164-508]. It authorizes Physician's Primary Care of St. Rose Pediatrics to disclose certain protected health information about my child/children.

Check and/or specifically describe the information to be used or disclosed:
_____Complete Health Record_____
_____Specific Dates of Service_____
_____Specific Conditions_____

I authorize the information to be released to:_____
_____

I authorize_____ to release my medical information.
This authorization is to be disclosed or used for the purpose of _____

_____

This authorization will be in force and in effect for 1 year at which time, this authorization expires.

I understand that this WILL NOT include the following information unless indicated and initialed below:
___Initials____AIDS or HIV infection
___Initials____Behavioral Health/Mental Healthcare
___Initials____STD Information
___Initials____TX for Alcohol/Drug Use

Are you leaving the practice? _____Yes _____No
If yes, Please explain_____
_____
_____

There will be a fee of 60 cents per page when releasing records directly to patient.

When my information is used or disclosed pursuant to this authorization, it may subject to re-disclosure by the recipient and may no longer be protected under the federal HIPPA Rule. I may revoke this authorization at any time, except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted in writing.

_____ _____ _____
Signature of Patient or Legal Representative | Date | Relationship to Patient

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