BRIGHT OAKS
Pediatric Center

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AUTHORIZATION TO RELEASE/DISCLOSE PROTECTED MEDICAL INFORMATION

Please read the form carefully and fill out completely.

1. I authorize	**2. To release information to**
Name of Sending Person/Organization:	Name of Receiving Person/Organization:
Full Address: Phone: Fax:	Full Address: Phone: Fax:

3. Information to be released: (Check All Applicable)

☐ Immunization Record ☐ Most Recent Well Visit Note ☐ Growth Charts ☐ Lead Test Results

☐ Lab Reports ☐ All Progress Notes ☐ Records relative to: _____ ☐ Others: _____

4. Records from the time frame of _____ to _____.

5. Purpose or need for disclosure:

☐ Continued Medical Care ☐ Payment of Insurance/Workers Comp Claims ☐ Legal ☐ Personal

☐ Other (If you are transferring out of our practice, please let us know why):_____

By my signature below I acknowledge the following:

6. I understand that this authorization shall be valid for 1 year unless otherwise indicated, and that I may revoke this consent in writing at any time except to the extent that the action has already been taken.

7. The requester may be provided with a copy of this authorization.

8. I understand that if my protected health information is disclosed to someone who is not required to comply with federal health insurance probability act and accountability act of 1996(HIPAA) regulations, then such information may be re-disclosed and would no longer be protected.

9. If this release pertains to alcohol, drug information, mental health problems, or psychotherapy, please note that this information has been disclosed to you from records protected by the federal confidentiality rules (42 CFR, part 2). The federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute an alcohol or drug abuse patient.

10. I understand that I have the right to inspect my child's protected health information and make authorization changes and copies, if needed.

11. I understand that a reasonable fee may be charged for duplication of records. The fee will include $0.76 per page for photocopying plus the actual cost of the postage and handling PLUS $22.88 for retrieval of records, if applicable.

_____ _____ _____
Patient name Date of Birth Date of Request

_____ _____
Current Address Daytime Phone Number

_____ _____ _____
Signature Printed Name of Authorized Parent/Guardian Relationship to Patient