CHILDREN'S MEDICAL GROUP, P.A.

PEDIATRICS
3920 AIRPORT BOULEVARD
MOBILE, ALABAMA 36608
610 PROVIDENCE PARK DRIVE, SUITE 201
MOBILE, ALABAMA 36695

Airport (251) 342-3810
Providence (251) 639-1300

Please allow 5 – 7 days for requested records to be sent.

Patient Name (Print) ______ SS or Health Record Number ______ Patient DOB ___/___/___

Address ______ City/St/Zip ______ Phone ______

I authorize ______ to use or release/disclose my health information as described below.

Address ______ Phone: ______ Fax: ______

Please identify the information to be released:

☐ Please release my entire record

-OR-

☐ Please release *only* the following information (check appropriate boxes and include other information where indicated):

☐ Problem List ☐ List of Allergies ☐ Immunization ☐ Medication List

☐Office Notes ______ ☐ History & Physical ______ ☐ Discharge ______ ☐ ER ______

☐ Lab results: ______ ☐ X-ray and imaging reports: ______

☐ Consultation reports: ______ ☐ Other (please describe): ______

The identified information will be used for the following purpose: ☐ Change to another Pediatrician

☐ My personal records ☐ Attorney/Legal ☐ Continued Care (Consult/Referral) ☐ other ______

Please initial each item below to indicate your understanding.

______ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or 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 by federal privacy laws or regulations.

______ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

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

The identified information may be used by or released to the following individual(s) or organization(s):

Name: Children's Medical Group- Providence

Address: 610 Providence Park Dr. Suite-201 Mobile, AL 36695 Phone: 251-639-1300 Fax: 251-639-1380

This authorization will expire on (insert date or event): ______ If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

______
Patient Signature / Parent / Legal Guardian Relationship Date ___/___/___

______
Witness Signature Date ___/___/___