CHILDREN'S MEDICAL GROUP, P.A.

PEDIATRICS

☐ 3920 AIRPORT BOULEVARD, SUITE-A
MOBILE, ALABAMA 36608
Airport (251) 342-3810

☐ 610 PROVIDENCE PARK DRIVE, SUITE 201
MOBILE, ALABAMA 36695
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** 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: _____

Address: _____ Phone: _____ Fax: _____

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**
		____/____/____