DOCTORS FOR KIDS, PLC

PATIENT AUTHORIZATION FORM

RELEASE OF INFORMATION

PATIENT INFORMATION	Print Legal Name: _____ Date of Birth:_____ Street Address: _____ City: _____ State: _____ Zip: _____ Parents/Guardian:_____
Health Information Released FROM:	□ Doctors for Kids, PLC □ Other Person/Organization:_____ Address: _____ _____ Phone: _____FAX:_____
Health Information Released TO:	□ Doctors for Kids, PLC □ Other Person/Organization:_____ Address: _____ _____ Phone: _____FAX:_____
INFORMATION REQUESTED	□ Clinic Visit notes □ Immunization records □ Lab reports □ Xray reports Dates:_____ □ Other Doctors for Kids, PLC will only release records generated at our facility. If you need records from another facility you will need to contact that facility
PURPOSE FOR RELEASE	□ Personal Copy □ Moving □ Referral to specialist □ Insurance □ Changing Providers □ Other_____
METHOD OF DELIVERY	□ Mail **or** □ Pick up (**must be 7-10 business days after date signed**): _____ Picture ID is required when picking up records. Written permission is required if someone other than parent/ legal guardian or patient is picking information up.
CHARGES FOR COPIES	Requests for copies of medical records generated by Doctors for Kids, PLC. for personal use or to be sent to another physician will be at a charge of $25.00
AUTHORIZATION/ REVOCATION	This authorization will terminate in one year unless otherwise specified: _____. I understand that I may stop this release at any time by writing to Doctors for Kids, PLC. Once the health information has been released to another facility or provider, there is no way to cancel or stop the release. I understand that when the health information is released the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. I understand that I must sign this form to release my health information. X _____ X_____ Signature Date (If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.) _____ Relationship to patient (if not patient) **NOTE:** An adult patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. Legal documentation of the right of access by the signing individual may be required. ***A photocopy of this authorization is as valid as the original.***