AUTHORIZATION FOR RELEASE/REQUEST OF PROTECTED HEALTH INFORMATION

Release From:
Name: _____
Address: _____
_____
Phone: _____
Fax: _____

Release To:
Name: _____
Address: _____
_____
Phone: _____
Fax: _____

Patient (child) Name: _____ **DOB:** _____
Requestor Name: _____ **Relationship to Patient:** _____
Address: _____
Email: _____ **Child SS#:** _____ **(last 4)**

REQUESTING THE FOLLOWING MEDICAL RECORDS

- ☐ COMPLETE MEDICAL RECORDS **OR** DATE RANGE OF RECORDS REQUESTED: _____
- ☐ IMMUNIZATION RECORDS / GROWTH CHART
- ☐ SCHOOL FORMS
- ☐ DIAGNOSTIC TEST RESULTS
- ☐ CONSULT/THERAPY RECORDS
- ☐ OPERATIVE RECORDS
- ☐ PROGRESS NOTES
- ☐ OTHER (please specify): _____

MAY NOT INCLUDE INFORMATION RELATED TO (please initial):

- ☐ HIV/AIDS __
- ☐ MENTAL HEALTH _____
- ☐ DRUG/ALCOHOL ABUSE _____
- ☐ GENETIC COUNSELING/TESTING INFO _____

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse, and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above unless initialed or otherwise by law.

This authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration event or condition, the authorization will expire in **one year.**

I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. I understand that my protected health information or that of my child that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I further understand that Sunshine Pediatrics may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization. Patient Portal Proxy authorization will remain active until revoked. I understand that I will receive a signed copy of this form if requested.

Signature of requestor/Legal Guardian: _____
Phone Number: _____ **Date:** _____