AUTHORIZATION FOR RELEASE/REQUEST OF PROTECTED HEALTH INFORMATION

Request from:

Name_____

Address_____

Phone/Fax_____

Release to:

Name_____

Address_____

Phone/Fax_____

Patient (child's) Name: _____ Patient Date of Birth: _____
(Print Name)

Address:_____ Social Security #:_____(last4)

REQUESTING THE FOLLOWING MEDICAL RECORDS

☐ Complete Medical Record ☐ Immunization Records / Growth Chart ☐ Diagnostic Test Results (Lab/Path/Rad) ☐ Consult/ Therapy Records ☐ Operative Record ☐ Progress Notes ☐ Other: (please specify)_____	**MAY NOT** INCLUDE INFORMATION RELATED TO (please initial) ☐ HIV/AIDS Initial_____ ☐ Mental Health Initial_____ ☐ Drug and/or Alcohol Abuse Initial_____ ☐ Genetic Counseling/Testing Information Initial_____ 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 above or otherwise required by law.

The 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/ Parent / Legal Guardian _____

Requestor Name:_____ Relationship to Patient:_____

Phone Number _____ Date_____