"We Put Wheels On Wellness!"
www.kidsdoconwheels.org

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Medical Records and Health Care Information Release

Authorization for Use/Disclosure of Protected Health Information

I hereby request and authorize _____
to release, use or disclose Medical Records as described below:

Phone:_____ **Fax**:_____

_____ _____
Patient's Full Name (Last, First, Middle Initial) Date of Birth (mm/dd/yyyy)

_____ _____
Current Address Apt. # City / State / Zip

_____ _____ _____
Driver's License # Home Phone Cell/Work/Other Phone

This Authorization applies to the following date(s) of Service: _____
(Leave Blank for All Service Dates)

State Requirements for Complete Medical Records

Search, Retrieval & Other Direct Administrative Costs	Up to:$25.88
Copying Costs for Records in Paper form	Per page for pages 1-20: $0.97
	Per page for pages 21-100: $0.83
	Per page for pages over 100: $0.66

Reason for Request to Release Records:

□ *Physician/Hospital/Therapist Request* □ *Moving from Area* □ *Other (Please Specify):*_____

Where would you like requested records sent?

Name: _____

Address _____

City _____ State/Zip_____

Phone _____Fax _____

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. I understand that unless otherwise limited by state or federal regulations, I may revoke this Authorization at any time by presenting my revocation in writing except to the extent that the entity identified above has taken action in reliance on this Authorization. I further understand that this Authorization is specific to the information checked above, for the date(s) of service indicated, and for the purpose written above.

_____ _____ _____
Signature of Parent or Legal Guardian Printed Name Date

Relationship to patient_____. If relationship is other than parent, documentation of legal authorization(s) or Guardianship must be attached to this authorization.