

**AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**GULF SHORES PEDIATRICS, P.C.**

232 Office Park Drive, Gulf Shores, AL 36542  
Phone 251-968-2323

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**\*\*\*\*\*PLEASE MAIL RECORDS\*\*DO NOT FAX\*\*\*\*\***

**Patient Name:** \_\_\_\_\_ **Patient DOB** \_\_\_\_/\_\_\_\_/\_\_\_\_

**INFORMATION REQUESTED:** \_\_\_\_\_ **Complete Medical Record**  
\_\_\_\_\_ **Immunization Record\*Can be faxed with last physical\***  
\_\_\_\_\_ **Other**

**PURPOSE OF DISCLOSURE:** \_\_\_\_\_ **Continued Medical Care**  
\_\_\_\_\_ **Personal Use**  
\_\_\_\_\_ **Other** \_\_\_\_\_

\_\_\_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 the 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 the 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 to sign this form to ensure health care treatment.

**I authorize Gulf Shores Pediatrics, P.C. to** \_\_\_\_\_ **Release (or) to** \_\_\_\_\_ **Request the identified information from:**

**Provider or Clinic Name** \_\_\_\_\_

**Address** \_\_\_\_\_

**Phone#** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Fax#** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_  
**Signature**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**DATE**

**\*Relationship to patient:** \_\_\_\_\_ **Self** \_\_\_\_\_ **Parent** \_\_\_\_\_ **Legal Guardian**

\_\_\_\_\_  
**Witness Signature**

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