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

Amanda Calhoun Gold, MD___ Rebecca Lee Autrey, CRNP___

******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