Redmont Pediatric Associates, P.C.
805 St. Vincent's Drive, Suite 430, Birmingham, AL 35205
Phone 205.939.1250 Fax 205.939.1349
Christina Cordell, M.D. Sara E. Frese, M.D. Ashley Shafferman, M.D. Victoria Anderson, M.D.

Medical Records Release Form

Patient Name:_____
Date of Birth: _____

Patient Name: _____
Date of Birth: _____

Patient Address (City/State/Zip): _____ Phone Number: _____

Purpose of Release: (Check One)
Continuity of Treatment: _____
Change of Physician: _____

Please release: (Check One)
All Records: _____
Immunization Records: _____
Specific Dates: _____ to _____

I am requesting that my child's medical records be sent to:

Redmont Pediatric Associates, P.C.
805 St. Vincent's Drive, Suite 430
Birmingham, AL 35205
Fax Records to: 205-939-1349

From: _____
Doctor:_____
Phone Number: _____
City/State:_____

OR

I need Redmont Pediatric Associates to send my child's records to:

Practice Name:_____
Address: _____
City/State/Zip: _____
Phone Number: _____

I wish to: (Choose One)
Pick up records myself ___ Have records mailed ___ Have records faxed to: _____

I understand that if I choose to send ALL RECORDS to another practice it may include psychological/psychiatric records, alcohol/drug abuse, and/or AIDS/HIV information and I expressly consent to the release of this information.

Printed Parent Name: _____

Signature of Parent (If under age 14 this MUST be signed by parent or guardian) : _____

Signature of Patient (If age 14 or above): _____

I understand the information released will be limited to information necessary to fulfill the need or purpose for the disclosure. If I have authorized the disclosure of information to a recipient who is not subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), then the recipient may re-disclose the information and it may no longer be protected under HIPPA, a federal privacy law. This authorization is valid for ninety (90) days from the date signed unless otherwise noted. This Authorization only applies to treatment occurring before the date of the signature. I may decline to sign this Authorization. I understand that I may revoke this authorization in writing at any time by completing a form available from Redmont Pediatric Associates, P.C. If I revoke this authorization, the revocation will not apply to information that has already been released to this authorization. I understand that the patient's health care and payment for the patient's health care will not be affected if I do not sign this form. I understand that I may see and copy the information described on this form if I ask for it and I may receive a copy of this form after I sign it. I may be charged reasonable copy fees as indicated under state law for my request. I represent that I have the authority and voluntary grant permission for the information to be released as described above.