White Oak Pediatrics

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Print patient's full name ______________________ Birth date (Mo/Day/Yr) ______________

Street address ______________________ Social Security number ______________

City, State, Zip code ______________________ Phone (Home) ______________

At the request of the individual, I ______________________ (Patient's Name), do hereby authorize ______________ to release:

____ DISCHARGE SUMMARY
____ HISTORY & PHYSICAL
____ PROGRESS NOTES
____ OPERATIVE REPORTS
____ PATHOLOGY REPORTS
____ LABORATORY REPORTS
____ RADIOLOGY REPORTS
____ ECG/EEG/CARDIAC CATH
____ EMERGENCY REPORTS
____ OTHER

From the time period of ______________ to ______________.

____ I do ____ I do not authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO:

____
Name of Company/Agency/Facility/Person

____
Street Address

____
City, State, Zip code

PURPOSE OF DISCLOSURE:

____ REFERRAL TO SPECIALIST
____ LEGAL INVESTIGATION
____ CONTINUING CARE
____ INSURANCE ____WORKERS COMP
____ DISABILITY DETERMINATION
____ OTHER (SPECIFY) ______________________
____ CHANGE OF DOCTOR
____ PERSONAL

Please provide current daytime telephone number in the event we need to contact you: ______________________

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons of facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

______________________ ______________
Signature of Individual or Guardian or Personal Representative of Patient's estate
Date

PLEASE NOTE: THERE IS A CHARGE FOR MEDICAL RECORDS WHEN REQUESTED FOR PERSONAL REASONS OR PERMANENT TRANSFER. HEALTHPORT HAS BEEN CONTRACTED TO PROVIDE THIS SERVICE AND WILL INVOICE YOU DIRECTLY. THEIR PHONE NUMBER IS: 1-800-367-1500

MEDICAL INFORMATION RELEASED BY HEALTHPORT

____ ENTIRE ____ LAB ____ EKG
____ DS ____ IMMUN ____ OP
____ X-RAY ____ CLINIC ____ HP ____ PATH ____ OTHER

______________ ROI SPECIALIST ______ DATE
NUMBER OF PAGES