AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Please read both sides of this form carefully. The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), which became effective April 14, 2003, requires that all of the following elements must be completed for an authorization to be valid.

Patient Name ______________________________

Street Address ______________________________

City, State, & Zip Code ______________________________

Phone Number ______________________________

Date of Birth ______________________________

I hereby authorize that the protected health information regarding the above-named person be forwarded:

FROM: Person/Organization ______________________________

Address ______________________________

City, State, Zip ______________________________

Phone ______________________________

Fax ______________________________

TO: Person/Organization ______________________________

Address ______________________________

City, State, Zip ______________________________

Phone ______________________________

Fax ______________________________

Note: A fee of $25 is required in order to complete this request. Every effort is made to process records quickly, however it may take up to 21 days to complete the request.

Office Use Only:

______________Requested ______________Copied ______________Signed Approval

______________Paid $______________Cash/Check/Charge ______________Called to Pick Up

Purpose or Need for Information:

Disclosure will include (check all that apply):

___ Face Sheet	___ History & Physicals	___ Laboratory Reports
___ Operative Report	___ Discharge Summaries	___ Progress Notes
___ X-Ray/Radiology	___ Pathology Reports	___ Emergency Reports
___ Nurses Notes	___EKG/EMG/EEGs	___ Consultation Reports

___ Other: ____

Records for the period (dates) from __________________ to __________________

I understand that this authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent the action has already been taken to release this information. This authorization shall remain valid unless revoked but **will expire in one year after signing.** I have a right to inspect a copy of the health information to be released, and if I do not sign this authorization, the organization named above will not release my health information. The above named person/organization will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

____ ___________________

Signature of Patient Date

____ ___________________

Signature of Parent/Legal Guardian Date

Re-disclosure: Notice is hereby given to the patient or legal representative signing this authorization that Millennium Pediatrics cannot guarantee that the recipient receiving the requested health information will not re-disclose any or all of it to others.

Please tell us why you are requesting your health information by checking one of the following:

___ I am remaining a Millennium Pediatrics patient but also seeking care from an outside physician.

___ I am leaving Millennium Pediatrics because:

- ___ I am moving out of the area
- ___ I have a new insurance plan
- ___Other: ____