Alpine

Pediatrics

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Authorization to release the health information of:

Patient Name

Current Address City State Zip

Phone Number ( ) - Date of Birth / /

This Authorization is to release health information TO:

Individual Names

Address City State Zip

Phone Number ( ) - Fax Number ( ) -

This Authorization is to release health information from Alpine Pediatrics

Reason for Request

Please indicate the means by which you wish the health information to be sent

☐ Pick up in Person ☐ Mail ☐ Fax Date of Service / / ☐ All Dates of Service

Please indicate the information you would like released

☐ Office Notes ☐ Lab Reports ☐ Immunization Records ☐ Other Records as Specified

As provided in the Health Insurance Portability and Accountability Act, you have a right of access to inspect and obtain a copy of your health information contained in a designated record set. This right does not apply to: 1. Psychotherapy notes; 2. Information compiled in reasonable aniticipation of, or for use in a civil, criminal, or administrative action or proceeding; and 3. Protected health information that is: (a) subject to the clinical Laboratory Improvements Amendments of 1988, 42 USC 263a, to the extent the provision of access you would be prohibited by law; or (b) exempt from the Clinical Laboratory Improvements Amendments of 1988, pursuant to 43 CFR 493.3 (a)(2).

Once this facility discloses my health information by my request, it cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to adhere to this authorization or state and federal laws pertatining to the use and disclosure of my health information.

Request will remain in effect for authorization until the end of my LDS mission unless I provide a written notice or revocation to Alpine Pediatrics, P.C. If revoked, Alpine Pediatrics, P.C. may not be able to stop the use of your health information during the period the authorization was in effect.

Patient Signature Date / /

Printed Name