ALPINE PEDIATRICS

Authorization to Use and Disclose Protected Health Information

Authorization to release the health information of:

Patient Name: **See reverse side to add additional patients

Address	City	State	Zip
Phone Number ( ) -	Date of Birth / /		

This Authorization is to release health information to:

Name of Clinic or Individual:

Address	City	State	Zip
Phone Number ( ) -	Fax Number ( ) -		

This Authorization is to release health information from:

Name of Clinic or Individual:

Address	City	State	Zip
Phone Number ( ) -	Fax Number ( ) -		

Reason for Request

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

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

Please indicate the information you would like released

Office Notes ☐	Lab Report(s) ☐	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

Alpine Pediatrics, P.C., does not charge for the first ten pages of copies it makes of your personal health information. Alpine Pediatrics, P.C., does charge $0.10 per copied page of your personal health information after the first ten pages. Payment must be received before records will be released.

Request will remain in effect for six months from the date on this authorization 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.

Signature of Biological Parent or Legal Representative:		Date / /

Printed Name	Relationship to Patient

Patient Name:	Relationship to Patient: ☐ Same as previous			
Address ☐ Same as previou	City		State	Zip
Phone Number ( ) -	Date of Birth / /			
Patient Name:	Relationship to Patient: ☐ Same as previous			
Address ☐ Same as previou	City		State	Zip
Phone Number ( ) -	Date of Birth / /			
Patient Name:	Relationship to Patient: ☐ Same as previous			
Address ☐ Same as previou	City		State	Zip
Phone Number ( ) -	Date of Birth / /			
Patient Name:	Relationship to Patient: ☐ Same as previous			
Address ☐ Same as previou	City		State	Zip
Phone Number ( ) -	Date of Birth / /			
Patient Name:	Relationship to Patient: ☐ Same as previous			
Address ☐ Same as previou	City		State	Zip
Phone Number ( ) -	Date of Birth / /			
Patient Name:	Relationship to Patient: ☐ Same as previous			
Address ☐ Same as previou	City		State	Zip
Phone Number ( ) -	Date of Birth / /			
Patient Name:	Relationship to Patient: ☐ Same as previous			
Address ☐ Same as previou	City		State	Zip
Phone Number ( ) -	Date of Birth / /			
Signature of Biological Parent or Legal Representative:		Date / /		
Printed Name				