Primary Care Pediatrics
and Family Medicine
29869 Capshaw Road, Harvest, Al 35749
Phone:256-262-1040; Fax:877-384-6047

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO PRIMARY CARE PEDIATRICS AND FAMILY MEDICINE

*NOTE: PLEASE ALLOW UP TO 30 DAYS FOR PROCESSING.

FAILURE TO COMPLETE EACH SECTION WILL RENDER THIS AUTHORIZATION INVALID, AND THEREFORE IT WILL NOT BE PROCESSED.

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

PHONE NUMBER: _____

I HEREBY AUTHORIZE: _____
ADDRESS: _____
PHONE NO: _____FAX: _____
TO RELEASE OR DISCLOSE PROTECTED HEALTH INFORMATION TO PRIMARY CARE PEDIATRICS AND FAMILY MEDICINE, P.C

This consent and authorization may include, but is not limited to, release of medical, psychological, psychiatric, alcohol, drug abuse, STD, and HIV/AIDS information.

Purpose of Disclosure: __ Attorney __ Continued Care __ Disability/SSI __ Insurance __ Personal __ other

The specific information to be released is:

___ Entire Record ___ Psychological Testing ___ Psychiatric Evaluation ___ Medication Records
___ Treatment Plan ___ Radiology/Imaging Reports ___ Laboratory/Pathology Reports ___ History/Physical
___ Consultation Reports ___ Physician Orders ___ Discharge Summary Progress Note(s) Dates:
_____
Other: _____

Delivery Format: ___ Paper ____ Electronic Transfer

I understand that this consent is revocable, except to the extent that action has already been taken in reliance thereon. Request for revocation of this authorization must be in writing. This authorization will expire (i) one year, (ii) after the disclosure is made, or (iii) the date specified here: _____. To accomplish the purpose of the disclosure stated above. I understand that I will receive a copy of this Authorization form after I sign it.

_____ _____ _____
Signature of Patient/Representative Relationship to Patient Date

Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected under Title 45, CFR. PCPFM may not condition treatment or payment on whether you sign this authorization, unless this authorization is for the provision of research-related treatment or for the creation of health information for disclosure to a third party. 2021

DATE RECEIVED: _____
DATE RELEASED: _____

REV 11/2021