PEDIATRICS 459 **205-425-5440**
6250 Park South Drive **FAX 205-425-5513**
Bessemer Alabama 35022

PATIENT NAME _____

ADDRESS_____

PHONE NUMBER_____**DATE OF BIRTH**_____

THIS AUTHORIZATION APPLIES TO THE FOLLOWING INFORMATION:

___ All information: I understand that the information may contain psychiatric/psychological,alcohol/drug abuse/AIDS/HIV information/and or other sensitive information and I expressly consent to the release of this information.

____ Only the following records or types of information:

_____

_____

Treatment Dates: from (month,day,year) ____/____/_____ to (month/date/year ____/____/_____
The information may be released as follows:
(Please check FROM whom the information is released and TO whom it goes)
From__ OR To__ Pediatrics 459
From __ OR To__ external Individual/Organizational (Please provide address/phone #)
_____

Purpose of the release:
Continuity of treatment____ Other (Please specify): _____

I understand the information release will be limited to information necessary to fulfill the need or purpose of this disclosure. If I have authorized the disclosure of Information to a recipient who is not subject to the Health Insurance Portability and Accountability Act of 1996 (HIPPA), then the recipient may re-disclose it and it may be no longer protected under HIPPA, a federal privacy law. This authorization is valid for (90) days from the date of the signature, unless otherwise noted. This Authorization only applies to treatment occurring before the date of signature. I may decline to sign this Authorization. I understand I may revoke this authorization in writing at any time by completing a form available from Pediatrics 459. If I revoke this authorization, the revocation will not apply to information that has already been released in response to this authorization. I understand the patient's health care and the payment for the patient's health care will not be affected if I do not sign this form. I understand I may see and copy the information described on this form if I ask for it, and may receive a copy of this form after I sign it. Before requesting medical record copies, please ask about the copy fee by law that may apply. I represent that I have the authority to and voluntarily grant permission for the information to be released as described above.

Patient/Parent/legal guardian. Print_____ Parent/Legal Guardian Signature_____

Patient Signature if 14 or older _____Witness Signature for patient/parent_____