Tuscaloosa Pediatrics, PC
4880 Harkey Lane
Tuscaloosa, AL 35406
Telephone: 205-333-8222
Fax: 205-333-8233

HIPAA Authorization for Release of Information

Patient Name: ____________________ __________ ______________________________
First Middle Initial Last

Date of Birth: _____/_____/_____ Home Phone: _____/_____/__________

Address: ____

City: ______________________ State: _______ Zip Code: ______________

I hereby authorize Tuscaloosa Pediatrics, P.C. to release information from my medical records to:

Name: ____

Street Address/P.O. Box: ______________________________________

City: ______________________ State: _______ Zip Code: ______________

Telephone #: ______________________ Fax #: ______________________

for the purpose of (e.g. consultation with a physician of another specialty, legal or insurance purposes).

Information to be released is to include: (Please circle Yes or No)

All Physician Notes	YES	NO
Treatment Summary	YES	NO
X-Ray Reports	YES	NO
Laboratory Reports	YES	NO
Itemized Bill	YES	NO

Other (Specify) ______________________________

I understand and agree to pay a fee for copying the medical records.

______________________________ ______________________
Parent/Legal Guardian Signature Date

______________________________ ______________________
Relationship to Patient Expiration Date of Release

I understand the information released will be limited to information necessary to fulfill the need or purpose for the 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 ("HIPAA"), then the recipient may re-disclose it and it may no longer be protected under HIPAA, a federal privacy law. This Authorization is valid for 90 days from the date of signature. 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 Tuscaloosa Pediatrics, P.C. If I revoke this authorization, the revocation will not apply to information that has already been released in response to the 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 I 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.