**Tuscaloosa Pediatrics, PC**
**657 Helen Keller Blvd**
**Tuscaloosa, Alabama 35404**
**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 obtain my medical records from:

Name: _____

Street Address/P.O. Box: _____

City:_____ State:_____ Zip Code:_____

Telephone #:_____ Fax #:_____

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)_____

_____ _____
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 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.