LITTLE LEGENDS
Pediatrics, LLC
169 W High Street
Mt. Gilead, OH 43338
Ph: (419) 751-7050
Fax: (740) 513-4628

HIPAA Release Form

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid, and it will not be possible for your health information to be shared as requested.

Section I

I, (Guardian name) _____, give my permission for

(Previous PCP) _____ to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Patient's Name: _____ Patient's Date of Birth: _____

Section II – Health Information

I would like to give the above healthcare organization permission to: Check as appropriate.

☐ Disclose the following

1) all visit encounter notes (with the **EXCEPTION** of nurse triage notes and AVS)
2) Diagnoses
3) Growth charts
4) Immunization records
5) Lab/imaging results

OR

☐ Disclose my complete health record except for the following information.

- Completed forms such as daycare or sports forms.
- Communicable diseases including, but not limited to, HIV and AIDS
- Genetic information
- Other

Form of Disclosure:

☐ Electronic copy or access via a web-based portal

(Fax to 740-513-4628 or call our office for direct email.)

☐ Hard copy – Mail to 169 W. High Street, Mt. Gilead, OH 43338

Section III – Reason for Disclosure

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request.'

_____

_____

Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s)

Name: Dr. Martie Gravitt

Organization: Little Legends Pediatrics, LLC

Address: 169 W High Street, Mount Gilead, OH 43338-1214

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them

Section V – Duration of Authorization

This authorization to share my health information is valid:

☐ From _____To _____

☐ All records

☐ Other: _____

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to Previous providers office.

- If my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.
- Failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Section VI – Signature

Signature: _____ **Date**: _____

Print your name: _____

If this form is being completed by a person with legal authority to act on an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Relationship to the patient if applicable: _____