

PEDIATRIC & ADOLESCENT CLINIC
DR. REBECCA SY CHING, MD., FAAP

**PERMISSION TO RELEASE MEDICAL RECORDS AND/OR AUTHORIZATION FOR
EXCHANGE OF CONFIDENTIAL INFORMATION**

PATIENT NAME: _____ **DOB:** _____
CURRENT ADDRESS: _____
CELLPHONE: _____ **ALTERNATE PHONE:** _____

PURPOSE OF REQUEST:

- ☐ CHANGE DOCTORS
- ☐ DOCTOR CONSULTATION
- ☐ MOVING/RELOCATING
- ☐ LEGAL REASONS
- ☐ SELF USE (PATIENT/REPRESENTATIVE WILL BE CHARGED A FEE)
- ☐ CONTINUITY OF CARE
- ☐ TELEPHONE COMMUNICATION
- ☐ OTHERS

INFORMATION TO BE DISCLOSED – General Medical Information:

Describe the type of protected health information (PHI) you are authorizing to be used and/or disclosed.

- ☐ Physician notes and medical records
- ☐ Imaging (x-rays, MRI, CT Scan, etc.)
- ☐ Lab Reports
- ☐ Immunization history
- ☐ School: general/special educational and/or discipline records, testing/evaluation results, counseling information

I AUTHORIZE INFORMATION TO BE RELEASED FROM:

NAME OF FACILITY: _____
NAME OF DOCTOR: _____
ADDRESS: _____
TELEPHONE NUMBER: _____ **FAX NUMBER:** _____

I AUTHORIZE INFORMATION TO BE RELEASED TO:

NAME OF FACILITY: _____
NAME OF DOCTOR: _____
ADDRESS: _____
TELEPHONE NUMBER: _____ **FAX NUMBER:** _____

EXPIRATION OF RELEASE/AUTHORIZATION

This authorization is valid for 90 days or until (specific date) _____ and may be revoked by the patient or representative orally or in writing at any time by contacting our HIPPA Privacy Officer. However, I understand that I may not revoke this authorization for any actions that have already occurred as instructed in this consent.

I understand that, by signing this form, I am confirming my release/authorization for use and/or disclosure of PHI described in this form with the people and/or organizations named in this form. It may re-disclosed by the recipient without the knowledge or consent of our clinic or you. This information may not be protected by Federal privacy regulation. I give authorization to fax my medical information. I understand the risk involved in faxing records and confidentiality at the receiving end cannot be guaranteed. All faxed information will contain a confidentiality statement and instructions for returning misdirected information.

PRINT NAME: _____ DATE: _____

SIGNATURE: _____

ADDITIONALLY, PROTECTED MATERIAL: Your general medical information may contain references to your mental state, drug and alcohol conditions, or HIV status or sexually transmitted diseases. Release of this information in your general medical permit Ching's Pediatrics, to release documents that may contain such information in my general medical record at this time.

1. Mental State and/or Behavioral Health Issues: I specifically consent to disclose such records as they require a separate authorization for complete release.

SIGNATURE OF PATIENT (OR LEGALLY RESPONSIBLE PERSON – RELATIONSHIP TO PATIENT) DATE

2. Drug and Alcohol Conditions: I specifically consent to disclose such records as they require a separate authorization for complete release.

SIGNATURE OF PATIENT (OR LEGALLY RESPONSIBLE PERSON – RELATIONSHIP TO PATIENT) DATE

3. Sexually Transmitted Disease and HIV/AIDS: I specifically consent to disclose such records as they require a separate authorization for complete release.

SIGNATURE OF PATIENT (OR LEGALLY RESPONSIBLE PERSON – RELATIONSHIP TO PATIENT) DATE

WITNESS: _____ DATE: _____