Request of Medical Records from All Star Pediatrics, PC

HIPAA Compliant Request & Authorization to Release Protected Medical Information to:

Name: _____ Phone_____

Address: _____ City: _____ State: _____ Zip Code:_____

Patient Name D/O/B _____
Patient Name D/O/B _____
Patient Name D/O/B _____
Patient Name D/O/B _____

I am requesting my child/children's PHI to be disclosed for the following purpose:

- ☐ For a second opinion
- ☐ Residence/Moved
- ☐ Age
- ☐ Specialist
- ☐ Dissatisfied with Care
- ☐ Insurance
- ☐

I authorize the specific records chosen below to be released to the entity listed above

- ☐ Immunization / Last physical
- ☐ Complete Chart
- ☐ Services from _____ To _____

HIV, Behavioral Health or Drug and Alcohol Abuse/Treatment information contained within the dates of services I specified above are to be released through this authorization unless specified below:

DO NOT RELEASE (check all that apply)

- ☐ Treatment of STD's (Sexually Transmitted Diseases and / or HIV testing results
- ☐ Psychiatric Problem
- ☐ Drug or Alcohol Abuse

This authorization expires ninety (90) days from the signature, or at the following event:_____. I may invoke this authorization at any time by mailing or personally delivering a signed written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effect upon receipt, except to the extent that the recipient has already taken action in reliance on this authorization. I am entitled to a copy of this authorization upon my request. I am may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits. The recipient of this protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law. Where permitted, the information I am requesting to be disclosed may sometimes be re-disclosed by the recipient and may no longer be protected by law. I am entitled to notice if my protected the health information is used for marketing and results in remuneration to the provider. I hereby acknowledge that I have real and fully understand the above statement as they apply to me.

_____ _____

Signature of Parent/Guardian Relationship to Patient DATE