PARTNERS IN PEDIATRICS, LLC

8160 Seaton Place ● Montgomery, AL 36116 ● Phone 334-272-1799 ● Fax 334-272-4876

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please Allow 3 to 4 business days for approval and certified mail delivery or pick up.

Please Release Records To:	Records Requested From:
Name	Name
Attention	Attention
Address	Address
City/State/Zip	City/State/Zip
Phone: Fax:	Phone: Fax:

Health Information Requested	Reason for Requesting Records
( ) Complete Medical Records	( ) Moving/Transferring to a New Physician for Continued Care.
( ) Immunization Records	***By moving or transferring records you will no longer be a patient of Partners in Pediatrics.***
( ) Date(s) of Service:	( ) Legal Proceedings - ***CERTIFIED COPY REQUIRED***
( ) Other (Specify):	( ) Other (Specify):

Patient(s) Name:

Attached additional Names if Necessary

First	Middle	Last	Date of Birth
First	Middle	Last	Date of Birth

Authorization

By signing this authorization, I authorize the use and disclosure of my protected health information as requested. I understand that the information may be re-disclosed by the recipient and may no longer be protected by the federal HIPAA privacy rule. I do not have to sign this authorization to receive treatment from Partners in Pediatrics. I have the right to revoke this authorization except to the extent that Partners in Pediatrics has acted in reliance upon this authorization.

$6.50 Per Patient Charge for Medical Records

Indicate Preference: ☐ **Prefer to Mail** ☐ **Prefer to Pick Up**

Printed Name	Signature	Relationship to Patient
Address/City/State/Zip		Phone Number
Date Signed	Witness	

This authorization expires 90 days from the date signed, or _____

Medical records received from your previous doctor are reviewed by your Partners in Pediatrics physician. After review your records will be scanned into a chart created for you. If you would like a copy of your records please notify our medical records coordinator, otherwise they will be shredded for your privacy. Thank you!

Office Use Only

Physician Approval:	
Date Received:	
Date Sent:	**ATTACH CERTIFIED MAIL RECEIPT HERE**
Person Sending Records:	
Parent/Guardian Signature: (Picking Up)	