Huntsville Pediatric Associates
Release of Medical Information

Phone 256.888.5437 Fax 256.705.1156

2004 Airport Road • Huntsville, AL 35801

NOTE: We ask that we be allowed 10 to 14 working days to process a release of medical information.

If a patient is fourteen years or older he/she must sign for the release of their medical records. There are no exceptions unless the child is physically or mentally handicapped.

Patient Name: _____ DOB: _____

By signing this form, I _____ authorize Huntsville Pediatric Associates, LLC to use, release, or disclose the protected health information described below to:

Name and Address of Person and/or Organization to Whom Information Should be Sent:

I understand that my records may contain information regarding my mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS - related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named above. _____ (Initial)

Purpose of Disclosure:

_____ Leaving Practice	_____ Referral to Specialist
_____ Insurance Purposes	_____ Relocating/Transfer

I authorize the following information to be sent to the address above:

Copies of all Medical Records from:	____ / ____ / ____ Mo Day Year	____ / ____ / ____ Mo Day Year
_____ Other (Please specify in provided area)*	*	

I have been provided a copy of Huntsville Pediatric Associates, LLC *Notice of Privacy Practices* and any charges that may be associated with this authorization. I have discussed any concerns I may have about the use, release, and disclosure of my health information with Huntsville Pediatric Associates, LLC's Privacy Officer or other appropriate office personnel.

I understand that the recipient listed above may redisclose this released medical information. I do not hold Huntsville Pediatric Associates, LLC responsible for the use or misuse by others of my health information disclosed under this authorization. I release Huntsville Pediatric Associates from any legal liability that may arise from this authorization.

Patient Signature: _____ ***Date:*** _____

SSN: _____ ***DOB:*** _____

Relationship to Patient: _____ ***Parent Phone #*** _____