

# FORM B

## PEDIATRIC ASSOCIATES

### REQUEST TO RELEASE, COPY, OR INSPECT PROTECTED HEALTH INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_ Chart #: \_\_\_\_\_

Street

City, State Zip

Phone # \_\_\_\_\_

**For Record Release or Copies:** By signing this authorization, I authorize the party listed below to use and/or disclose certain protected health information (PHI) about me / my child.

#### This authorization permits:

\_\_\_\_\_ to use or disclose to \_\_\_\_\_  
Provider's Name New Provider, Specialist, or Person Receiving Copy

\_\_\_\_\_ Street Address \_\_\_\_\_  
Street Address

\_\_\_\_\_ City, State ZIP \_\_\_\_\_  
City, State ZIP

\_\_\_\_\_ Phone # \_\_\_\_\_  
Phone #

**Information to be Released / Copied:** ( ) All pertinent medical records including immunizations and lab tests

( ) Day sheets – dates: \_\_\_\_\_ ( ) Lab Info - dates: \_\_\_\_\_

( ) Other: \_\_\_\_\_

**Information to be Excluded / Not Released:** ( ) Mental Health Records ( ) Drug/Alcohol Treatment

( ) HIV Testing ( ) Sexual Assault/Victimization Records ( ) Other: \_\_\_\_\_

**\*\*\* BE SURE TO REVIEW ANY RESTRICTIONS PRIOR TO COPYING / RELEASING \*\*\***

**Reason for Record Release or Copy:** ( ) Personal copy <see below / charges apply>

( ) Over age 21 ( ) Insurance change ( ) Moving / Changing providers ( ) Referral to Specialist

( ) Unhappy with Practice (Please state why) \_\_\_\_\_

( ) Other: \_\_\_\_\_

**For Patient or Guardian Inspection / Copy Requests:** ( ) Check here

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the cost of supplies and labor, and postage related to the production of my information. I understand that the charge for this service is: **\$1.00 per page for the first 25 pages, then \$.25 for each page thereafter.**

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date\*

\*Inspection requests are valid on the date of signature only

\*Release/Copy requests expire 30 days from signature date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

*Prohibition of Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by law. Any further disclosure is strictly prohibited unless the patient/guardian provides specific written consent for subsequent disclosure of this information. These records may be protected by federal regulation (42 CFR, Part 2).*

**FOR INTERNAL PURPOSES ONLY: Name & Title of Person Releasing Records** \_\_\_\_\_

Method of Transfer:  Mailed on (date) \_\_\_\_\_ Certified? (certification #) \_\_\_\_\_

Faxed to (number) \_\_\_\_\_ on (date) \_\_\_\_\_

Picked up by (name) \_\_\_\_\_ on (date) \_\_\_\_\_

Verification of Identification Performed?  YES  NO Form of Identification: \_\_\_\_\_