Jami Adams, M.D., P.A.
4542 S. 14th St.
Abilene, TX, 79605
(325) 695-1600
Fax (325) 695-1601
www.adamspediatrics.com

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize you to release confidential health information about my child, by releasing a copy of her or his medical records or a summary or narrative of her or his protected health information (PHI), to the person(s) or entity listed below.

Name of child:	Date of Birth:	SSN:

Please release the following information:

❑ **complete medical record*** (to include immunization record).

❑ other (specifically describe the information to be used or disclosed, such as date[s] of services, type of services, level of detail to be released, origin of information, etc.):

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This information is to be released ❑ from: ❑ to:

Name:		Telephone:
Address:		Fax:
City:	State	Zip:

❑ from: ** **❑ to:**

Jami Adams, M.D.
4542 South 14th Street
Abilene, TX 79605
Telephone (325)695-1600
Fax (325)695-1601

Release information via: ❑ pick up ❑ mail ❑ fax immunization record only

The information will be used or disclosed for the purpose of **medical care**.

This authorization will expire after 180 days or upon receipt of the requested medical record by Jami Adams, M.D.

The practice will not receive payment or other remuneration from a third party in exchange for using the PHI.

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility for disclosure of the above information to the extent indicated and authorized herein.

I do not have to sign this authorization in order for my child to receive treatment from Jami Adams, M.D. In fact, I have the right to refuse to sign this authorization. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at Jami Adams, M.D., P.A., 4542 South 14th Street, Abilene, Texas, 79605.

______________________________ ______________________________
Signature of Parent or Legal Guardian Date

______________________________ ______________________________
Print Name of Parent or Legal Guardian Relationship to Patient

_____ Initial **I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners**.

*Please note that the health information released may include information obtained from other treating facilities or providers.

**Medical records to be released from Jami Adams, MD, will be released at no charge if they are sent directly to another medical provider. Medical records released to any other person(s) or entity will be charged according to the rulings set forth by the Texas State Board of Medical Examiners.