Adams Pediatrics
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Authorization to Disclose Protected Health Information

This form is for all record requests.

This information is to be released ❑ from: ❑ to:		
Name:		Telephone:
Address:		Fax:
City:	State	Zip:
Email:		

❑ from: ❑ to:

Adams Pediatrics
6300 Regional Plz, Ste 250
Abilene, TX 79606-5222
Telephone (325)695-1600
Fax (325)695-1601

Release information via: ❑ pick up ❑ electronically (secure website)
❑ U.S. mail ❑ fax immunization record only

Please note: *Medical records longer than 10 pages will be available only electronically in .PDF format.*

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)

Name of child:	Date of Birth:
Name of child:	Date of Birth:
Name of child:	Date of Birth:
Name of child:	Date of Birth:

1. Please release the following information:

❑ Complete Health Record

❑ Clinical Documentation of Physical

❑ Immunization Records

❑ Radiology and Diagnostic Imaging Reports

❑ Laboratory tests (please specify)

❑ Other (please specify):

2. If applicable, I also give permission for the following "Sensitive Protected Health Information" to be disclosed (please initial below):

❑ Acquired Immunodeficiency Syndrome (AIDS) or Infection with Human Immunodeficiency Virus (HIV)
❑ Behavioral Health Services / Psychiatric Care
❑ Treatment for Alcohol and/or Drug Abuse
❑ Sexually Transmitted Diseases (STD)
❑ Genetic Counseling / Testing

_____ Initial

I understand that the information disclosed pursuant to this Authorization, **except** information protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state and federal laws.

3. The purpose for which disclosure is authorized (*check where applicable*)**:**

❑ Medical Care ❑ Insurance ❑ Benefit eligibility ❑ Immunization

❑ Other:

4. 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.

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the provider(s) of care. **I understand** that the revocation will not apply to information that has already been released in response to this authorization. **I understand** that the revocation will not apply to my insurance company when the law provides my insurer with the right to review or contest a claim. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

(Date) _____/_____/_____ **If I fail to specify an expiration date, event, or condition, this authorization will expire in 90 days. If this authorization pertains to oneself as the patient, the expiration date can be documented as unlimited. If documented as such,** (Initial here _____) **it is the responsibility of the individual to notify the practice of any life changes, i.e. guardianship, so that appropriate documentation is given for the change.**

6. I understand that any disclosure of healthcare information carries with it the potential for unauthorized and future re-disclosures, as allowed by HIPAA and other federal privacy rules. If I have questions about disclosures of my health information, I can contact my provider of care.

7. This facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____

Signed: Parent, Legal Guardian, or Legal Representative (*Relationship if not Patient)*

ID Provided: _____ Date _____/_____/_____

Witness or Notary (This Authorization must be notarized if information is being released to an attorney or court.)