kids first pediatrics

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Authorization to Release Protected Health Information

Patient Name (Last)	(First)	(MI)
Date of Birth	Phone Number	

☐ I, the undersigned, do hereby authorize Kids First Pediatrics, LLC to **receive** the above-named patient's PHI **FROM:**

☐ I, the undersigned, do hereby authorize Kids First Pediatrics, LLC to **release** the above-named patient's PHI **TO:**

Facility & Provider		
Street Address	City/State	Zip
Phone Number	Fax Number	

Reason for transfer or release of PHI:

☐ Insurance Change ☐ Transfer of Care ☐ Continuity of Care ☐ Legal

☐ Moving Out of Area ☐ Specialty Consultation ☐ Personal

Specific PHI to be transferred or released:

☐ Entire Medical Record ☐ Most Recent Well Child Check & Shot Record ☐ Other: _____

I understand that the patient's entire medical treatment record, including information pertaining to drug or alcohol abuse and psychological or psychiatric treatment, will be provided unless I specify that the following information should NOT be released:

_____

Specific Information NOT to be released

_____

Signature

There is a fee to release medical records to a legal parent or guardian. Per state law, you may be charged up to $1.00 for each page of the first 25 pages, $0.50 for each page in excess of 25 pages, and a search fee of $5.00 for each patient health record requested.

Release or transfer of the specified information to any person or entity not specified above is prohibited. I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I mist do so in writing and mail my written revocation by certified mail, return receipt requested to the Privacy Officer at Kids First Pediatrics. I understand the revocation will not apply to information that has already been released in response to this authorization. I also understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that once this health care information is released, redisclosure of it by the recipient may no longer be protected by law.

This authorization is valid until ____ or two years from the date signed. Only the records from the facility/provider listed above can legally be released. Any record from another physician must be obtained from them.

I understand I have a right to receive a copy of this request.

_____

Patient/Parent/Legal Guardian Printed Patient/Parent/Legal Guardian Signature Date

_____

Witness Signature Date