

GALES FERRY PEDIATRIC GROUP

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RELEASE OF PROTECTED HEALTH INFORMATION/RECORD RELEASE

PATIENT NAME: _____

DOB: ____/____/____

ADDRESS: _____ PHONE: ____ - ____ - ____

CITY: _____ ST: _____ CELL: ____ - ____ - ____

*****This section must be filled out completely or this will delay records*****

I HEREBY AUTHORIZE GALES FERRY PEDIATRICS TO (**RECEIVE / DISCLOSE**) MY HEALTH INFORMATION (**TO / FROM**)
please circle one

ADDRESS _____ CITY _____ ST. _____ ZIP _____

PHONE# _____ FAX# _____

PLEASE RELEASE THE FOLLOWING INFORMATION (CIRCLE)

ENTIRE MEDICAL RECORD RECORDS FROM _____ TO _____

RELATING TO A SPECIFIC PROBLEM IMMUNIZATION AND PHYSICAL EXAMS

I UNDERSTAND:

*ONCE THE OFFICE DISCLOSES HEALTH INFORMATION, THE PERSON OR ORGANIZATION THAT RECEIVES IT MAY RE-DISCLOSE IT PRIVACY LAWS NO LONGER PROTECT IT.

*THERE IS A CHARGE OF \$0.50 PER PAGE IN ADDITION TO POSTAGE FEES

*I MUST PROVIDE PROOF OF MY IDENTITY UPON PICK UP IF NOT DIRECTLY TRASFERRING TO ANOTHER HEALTH ORGANIZAITON

*THE INFORMATION IN MY HEALTH RECORD MAY INCLUDE INFORMATION RELATING TO SEXUALLY TRANSMITTED DISEASE, ACQUIRED IMMUNODIFICIENCY SYNDROME (AIDS), OR HUMAN IMMUNODIFICIENCY VIRUS (HIV)(IT MAY ALSO INCLUDE IFORMATION ABOUT BEHAVIORAL OR MENTAL HEALTH SERVICES, AND TREATMENT FOR ALCOHOL AND DRUG ABUSE

*THIS AUTHORIZATION WILL BE VALID FOR ONE YEAR FROM THE DATE ABOVE

I GIVE GALES FERRY PEDIATRIC GROUP THE AUTHORIZATION TO LEAVE A MESSAGE REGARDING MEDICAL RECORD PICKS UP.

_____/_____/_____
PARENT OR GUARDIAN SIGNATURE IF PATIENT IS A MINOR DATE

_____/_____/_____
SIGNATURE OF PARENT, GUARDIAN, PATIENT UPON RELEASE AND PICK UP OF RECORDS DATE

SIGNATURE OF WITNESS