**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

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

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I authorize the protected health information regarding the above-named person to be exchanged between:**

***From:*** ***To:***

Provider/Institution Provider/Institution

Address Address

City City

State/ZIP State/ZIP

Phone Phone

Fax Fax

**Disclosure will include**: (check all that apply)

\_\_ All records- (Includes, but not limited to HIV, Mental Health and Substance Abuse Information)

\_\_ History & Physical \_\_\_ Lab Reports \_\_Immunizations

\_\_ Progress Notes \_\_\_Radiology Reports \_\_Substance Abuse

\_\_ Mental Health

\_\_ Other

**Information in checked boxes may be released from**:

\_\_ All Dates

\_\_ Records for the period (dates) from \_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose of this information is**:

\_\_ Seeking care from a specialist physician

\_\_ Relocation: My new address is

\_\_ New insurance and must transfer care: My new insurance is

\_\_ Other (please specify):

**This authorization expires**:

\_\_ On (date):

\_\_ When the following event occurs:

\_\_ In 90 days from the date signed.

I also understand that this authorization is subject to revocation/withdrawal by me at any time in writing to Apple-a-Day Pediatrics except if the action has already been taken to release the information. I have the right to inspect a copy of the health information to be released. My child’s treatment, payment or eligibility may be conditioned on obtaining the authorization. Apple-a-Day will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others. Once health care information is disclosed, the person or organization that receives it, may re-disclose it. Privacy laws may no longer protect it.

***\*I understand that there may be a fee required for this request.***

Parent/Legal Representative Signature:

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_