ADVENTURES IN PEDIATRICS
3719 E MERIDIAN LOOP, SUITE D
WASILLA AK, 99654
PHONE (907) 373-7337
FAX (907) 357-9029

HIPPA COMPLIANT

MEDICAL RECORDS RELEASE OF INFORMATION AUTHORIZATION

*PATIENT NAME*_____ *DOB*_____ *SSN*_____
*ADDRESS*_____ *CITY*_____ *STATE*_____ *ZIP*_____
*PARENT NAME (S)*_____
*PHONE*_____ *CELL*_____ *WORK*_____

I REQUEST MEDICAL INFORMATION FROM:

*HOSPITAL/PHYSICIAN*_____
*ADDRESS*_____ *CITY*_____ *STATE*_____ *ZIP*_____
*PHONE*_____ *FAX*_____

I AUTHORIZE THIS INFORMATION TO BE DISCLOSED TO:

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I AUTHORIZE THE FOLLOWING INFORMATION TO BE RELEASED FROM MY RECORD (S)

_____*ENTIRE MEDICAL RECORD* _____*LABORATORY REPORTS* _____*CONSULTATION*
_____*HISTORY & PHYSICAL* _____*OPERATIVE NOTES*
_____*ER REPORT* _____*DISCHARGE SUMMARY*
_____*OTHER*_____

BY INITIALING THE SPACE BELOW, I SPECIFICALLY AUTHORIZE THE USE AND/OR DISCLOSURE FOR THE FOLLOWING HEALTH INFORMATION AND/OR MEDICAL RECORDS. IF SUCH INFORMATION AND/OR RECORDS EXIST:

_____*INFORMATION RELATING TO MENTAL HEALTH CONDITIONS* _____*(INITIALS)*
_____*INFORMATION RELATING TO DRUG AND/OR ALCOHOL ABUSE* _____*(INITIALS)*
_____*INFORMATION RELATING TO HIV TESTING, INFECTION STATUS, OR CARE AND TREATMENT*

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS PROTECTED BY FEDERAL CONFIDENTIALITY RULES. THE FEDERAL RULES PROHIBIT MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS EXPRESSLY PERMITTED BY THE WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS TO OR AUTHORIZED REPRESENTAITVE. THIS AUTHORIZATION WILL EXPIRE 180 DAYS FROM THE DATE OF SIGNING. I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME AND DO NOT HOLD LIABLE THE PHYSICIAN/HOSPITAL FOR RECORDS RELEASED PRIOR TO THE DATE OF REVOCATION.

*PATIENT/AUTHORIZED REPRESENTATIVE SIGNATURE:*_____
(If other than patient)

*RELATIONSHIP TO PATIENT:*_____ *DATE:*_____