PediaTrust, LLC

Authorization for Release of Patient Health Information Date: _____

Patient Name: _____
Patient Date of Birth: _____
Address: _____
City / State / ZIP: _____
Telephone #: _____

I hereby authorize the protected health information regarding the above named person to be released to:

Person/Institution: _____
Address: _____
City/State/ZIP: _____
Fax: _____

If record is needed because you are leaving the practice, what is your reason for leaving?

☐ "Aged out" ☐ Moving out of area ☐ Unhappy with practice or physician

The type of information to be used or disclosed is as follows:

☐ GROWTH CHART ☐ ENTIRE HEALTH RECORD
☐ IMMUNIZATION RECORD ☐ OTHER (please specify)_____

Include the following sensitive information:

	Behavioral or mental health information and/or records *(the patient 12 or over must authorize this release)*
	Birth control *(the patient 12 or over must authorize this release)*
☐	Drug/alcohol diagnosis, treatment, and/or referral information *(the patient 12 or over must authorize this release)*
	HIV/AIDS related health information and/or records *(the patient 12 or over must authorize this release)*
	Information about sexually transmitted disease *(the patient 12 or over must authorize this release)*
	Pregnancy *(the patient 12 or over must authorize this release)*

☐ Genetic testing information and/or records
☐ Information about sexual assault/abuse
☐ Information about child abuse and neglect
☐ Domestic abuse of an adult with a disability

By my signature, I hereby authorize PediaTrust, LLC to use or disclose my health information in the manner indicated above.

Parent/Legal Guardian Signature:_____ Date:_____

Patient Signature:_____Date:_____
(If 12 yrs. or older and items in box checked for release)

Authorized individual to pick up records *(Photo ID will be required)*: _____

For Office Use Only:
Records reviewed by Provider: _____
Records Transfer Fees: _____ Amount Paid: _____