



# 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 <i>(the patient 12 or over must authorize this release)</i><br>Birth control <i>(the patient 12 or over must authorize this release)</i><br><input type="checkbox"/> Drug/alcohol diagnosis, treatment, and/or referral information <i>(the patient 12 or over must authorize this release)</i><br>HIV/AIDS related health information and/or records <i>(the patient 12 or over must authorize this release)</i><br>Information about sexually transmitted disease <i>(the patient 12 or over must authorize this release)</i><br>Pregnancy <i>(the patient 12 or over must authorize this release)</i> |
|---|
- 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: \_\_\_\_\_