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 ☐ Practice does not accept my insurance ☐ 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: __________

Reviewed December 2017