Thomasville Pediatrics
Archdale-Trinity Pediatrics

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: _____

Date of Birth (month/day/year): _____

SS#: _____

Good Contact #: _____

Responsible Party Name: _____

Address: _____
(street address)

_____
(street address, cont.)

_____
(city) (st) (zip)

Information Released From:

At the request of the individual, I _____,
(Your Name)

do hereby authorize _____,
(Facility Name)

located at_____,
(Facility address)

and at phone: _____ **, to release the following:**
(check appropriate box(s) below)

Information Released To:

_____
Name of Practice/Physician/Agency/Facility/Person

_____
(street address)

_____
(city) (st) (zip)

Phone: _____

☐ Birth to Current

☐ Specific Date of Service: (dates) _____ to _____

☐ Specific Condition_____

☐ Specific Medications: _____

☐ Other _____

Indicate if you agree or do not agree (check the appropriate box): ☐ I do ☐ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

Purpose of Disclosure (check the following):

☐ CONTINUATION OF CARE ☐ LEGAL INVESTIGATION ☐ WORKER'S COMP

☐ REFERRAL TO SPECIALIST ☐ INSURANCE ☐ DISABILITY DETERMINATION

☐ CHANGE OF DOCTOR ☐ PERSONAL .

☐ OTHER _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that if will not affect any information released prior to this notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or calls of person or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to who this authorization is furnished may not condition its treatment of me on whether or not I sign authorization.

Note: There will be a charge for any personal copy or the permanent transfer of your records. Health Port Solutions have be contracted to provide this service and will invoice you directly.

Signature: _____ **Date**: _____

OFFICE USE ONLY ☐ *FAXED* *#*_____ *PATIENT ACCOUNT #:* _____