Thomasville Pediatrics
Archdale-Trinity Pediatrics
Thomasville-Archdale Pediatrics Well-Child Clinic
Midway Pediatrics

(Office Use Only)
PATIENT ACCOUNT #: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____
(Nombre del paciente)

Date of Birth: _____ Sex: ☐ Male ☐ Female
(Fecha de nacimiento)

Contact Number: _____
(# de contacto)

Responsible Party Name: _____
(Persona responsable)

Address: _____
(Direccion) (street address)

_____
(city, state, zip)

Information Released From:

Practice/Facility Name: _____

Address: _____

_____

Phone: _____

Information Released To:

Practice/Facility Name: _____

Address: _____

_____

Phone: _____

At the request of the individual, I _____ do hereby authorize the above to release the following:

□ The last 2 years will be sent unless specified otherwise.

□ Specific date of service: (dates) _____ to _____

□ Other: _____

Indicate if you agree or do not agree (check 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

□ Change of Doctor □ Disability Determination □ Insurance □ Personal

□ Other: _____

I hereby authorize disclosure of 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 it 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 of 12 cent per page to mail or emailed for $6.50. CIOX has been contracted to provide this service and will invoice you directly. If you have any questions you can contact CIOX at 800-367-1500.

□Mail □Email: _____ □Fax: _____

Signature: _____
(Firma)

Date: _____
(Fecha)