Ravenswood Pediatrics
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HIPPA COMPLIANT REQUEST & AUTHORIZATION TO RELEASE PROTECTED MEDICAL INFORMATION TO RAVENSWOOD PEDIATRICS

Patient Name_____ Date of Birth_____

Phone Number_____ Address_____

I Hereby Give:

Facility/Physician/Person: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

(Full name & address must be complete to release records)

Permission to release my child's protected health information (PHI) to Ravenswood Pediatrics

I authorize the specific records chosen below to be released to the entity listed above:

☐ Complete record ☐ immunization

☐ Primary care physician notes ☐ other

☐ Services from _____ through _____

HIV, Behavioral Health, or Drug and Alcohol Abuse / Treatment information contained within the dates of service I have specified above are to be released through this authorization unless specified below:

DO NOT RELEASE: (Check all that apply)

☐ Treatment of STDs (Sexually Transmitted Diseases) and/or HIV testing results

☐ Drug or alcohol abuse

☐ Psychiatric Problems

This authorization expires ninety (90) days from signature or at the following event _____. I am requesting my child's PHI to be disclosed for the following purpose:

☐ For a second opinion ☐ Age ☐ Specialist

☐ Residence moved ☐ Dissatisfied with care received

☐ Personal reason ☐ Change in insurance

I may revoke this authorization at any time by mailing or personally delivering a signed written notice of revocation to the healthcare provider at which this authorization was executed, such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this authorization. I am entitled to a copy of this authorization upon my request. I may not be required to sign this authorization as a condition to obtaining treatment or payment or my eligibility for benefits. The recipient of this protect health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law. Where permitted the information I am requesting to be disclosed may sometimes be re-disclosed by the recipient and may no longer be protected by law. I am entitled to notice if my protected health information is used for marketing and result in remuneration to the provider. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

Signature of parent/Guardian/Patient Relationship to Patient Date

Witness Date