AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Patient Legal Name: _____ Date of Birth: _____/_____/_____
Daytime Phone _____-_____-_____
Are you authorizing release of your own records? ▫ Yes ▫ No
If not, what is your legal relationship to the patient? _____

Information To Release:
▫ Most recent well visit, all immunizations, all growth records
▫ Specified chart notes: _____
▫ Labs/Reports: _____
▫ Radiographic Information: _____
▫ Billing Records: _____
▫ Other: _____

I hereby authorize **(Sender)**:
▫ The Kids Clinic
▫ Facility Name: _____ Provider Name: _____
Address: _____ City: _____ St: ____ Zip: _____
Phone _____-_____-_____ Fax: _____-_____-_____

To be released to **(Receiver)**:
▫ The Kids Clinic
▫ Self *(please provide your address and phone number below)*
▫ Facility Name: _____ Provider Name: _____
Address: _____ City: _____ St: ____ Zip: _____
Phone _____-_____-_____ Fax: _____-_____-_____

For the purpose of:
▫ Transfer of care
▫ Adjunctive/Concurrent care
▫ Other: _____
Please initial for the following items to be included in this release of PHI:
_____ HIV, AIDS, or sexually-transmitted disease related records
_____ Mental health information
_____ Genetic testing information
_____ Drug, alcohol, or dependency diagnosis, treatment, or referral information
Federal regulations require a description of how much and what kind of information is to be disclosed.
Describe: _____

This authorization is effective immediately and shall remain in effect until _____/_____/_____ or one year if no date entered. I understand that I can revoke this consent at any time, unless disclosure has already occurred in compliance with this consent.

Patient or Legal Guardian **Signature:** _____ **Date:** _____/_____/_____

Patient or Legal Guardian **Printed Name:** _____

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