SPRINGVILLE PEDIATRICS

HIPAA Authorization to Release PHI

Patient Name (Last)	(First)	(MI)
Date of Birth	Social Security Number	
Street Address	State	Zip

I, the undersigned, do hereby authorize Springville Pediatrics LLC to release the above named patient's PHI to and/or receive the above named patient's PHI from:

_____
(Agency/Facility/Person)

_____
(Street Address) (City/State) (Zip)

_____
(Phone Number) (Fax Number)

Reason for transfer or release of PHI:

- ☐ Insurance Change
- ☐ Transfer of Care
- ☐ Legal
- ☐ Moving out of area
- ☐ Specialty Consultation
- ☐ Personal

Specific PHI to be transferred or released:

- ☐ Entire Medical Record
- ☐ Other: _____

I understand that the patient's entire medical treatment record, including information pertaining to drug or alcohol abuse and psychological or psychiatric treatment, will be provided unless I specify that the following information should NOT be released:

_____
Specific information NOT to be released

_____
Signature

There is a fee to release medical records to a legal parent or guardian. Per state law, you may be charged up to $1.00 for each page of the first 25 pages, $0.50 for each page in excess of 25 pages, and a search fee of $5.00 for each patient health record requested.

Release or transfer of the specified information to any person or entity not specified above is prohibited. I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and mail my written revocation by certified mail, return receipt requested to the Privacy Officer at Springville Pediatrics. I understand the revocation will not apply to information that has already been released in response to this authorization. I also understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that once this health care information is released, redisclosure of it by the recipient may no longer be protected by law.

This authorization is valid until _____or two years from the date signed. Only the records from this facility can legally be released. Any record from another physician must be obtained from them.

I understand I have a right to receive a copy of this request.

_____
Patient/Parent/Legal Guardian Signature Relationship to Patient Date

I attest to the identity of the above signature(s):

_____
(Print) Witness Name Witness Signature Date