Emerald Pediatrics

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Please allow 10 working days for this request to be processed

Patient Name ____ Date of Birth _____/_____/_____

Authorizes Emerald Pediatrics to release the following medical information to:
(Include Name, Address and Phone #)

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Please be sure that your account with our billing office is up-to-date before requesting release of records

This request and authorization applies to:

______ Health care information related to the following treatment, condition, or dates of treatment ____

______ Transfer of medical care to new practice/change of doctor

All medical records in our computer system are transferred to a disc in PDF format at no charge.
Any request for paper copies or if the paper chart has to be recalled from storage, a $25.00 charge will be assessed. Payment is required before records will be released.

Reason for transfer: ______ Moving out of area ______ Insurance ______Other

If other please explain:____

Forwarding Address: ____

This authorization is valid for 60 days from the date of signature and there may be fees to process it.

The patient can revoke this authorization at any time by notifying Emerald Pediatrics in writing. This would not affect any actions already taken by Emerald Pediatrics based upon this authorization.

I understand that I do not have to sign this authorization in order to obtain healthcare benefits (treatment, payment or enrollment or eligibility). However, I do not have to sign it to receive health care when the purpose is to create health information for a third party or take part in a research study.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. The privacy laws may no longer protect it.

I understand that the information disclosed may contain matter that is protected by Federal and State laws, including information which may relate to ALCOHOL, DRUG AND PSYCHIATRIC TREATMENT, AIDS AND/OR HIV TESTING AND/OR OTHER SEXUALLY TRANSMITTED DISEASES. I UNDERSTAND THIS WILL BE RELEASED UNLESS I SPECIFICALLY REQUEST THAT IT BE WITHHELD.

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Signature of patient or patient's authorized representative Date signed

FOR OFFICE USE ONLY

❒ **Billing Office** **Balance Due:____________** ❒ **Statement Attached/Sent** **Initials:____________**
❒ **Reviewed by Physician** **Physician Initials____________** **Date:____________**
❒ **Records mailed/picked up** **Date:____________**