JEFFERS, MANN, AND ARTMAN PEDIATRIC AND ADOLESCENT MEDICINE, P.A.

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Authorization to Use/Release/Disclose Health Information

Section A: (Must be completed for all authorizations)
I hereby authorize the use, release, and/or disclosure of my health information as described below. I understand the information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer protected by the Privacy regulations.

Patient Name: ____ **Date of Birth:** ____/____/_____

Persons/Organizations Providing the Information:

Name:_______________________________________

Address:____________________________________

____

Persons/Organizations receiving the information:

Name:_______________________________________

Address:____________________________________

____

I authorize the following information to be sent to the address above:

___ Copies of all Medical Records for the Period _____/____/____ to ____/____/____
Mo Day Year Mo Day Year

___ Copies of information described below for the Period ____/____/____ to ____/____/____
Mo Day Year Mo Day Year

___ History & Physical Examination ____ Lab, X-ray, etc Reports ____ Reports from Other Physicians

___ Complete Jeffers and Mann Pediatrics Medical Records – **Charge $15** payable at time of request

___ Immunization Records only - (If being released From Jeffers, Mann and Artman Pediatrics -- NO CHARGE)

___ Last Physical/Brief Summary (If being released From Jeffers, Mann and Artman Pediatrics -- NO CHARGE)

___ Other (Please Specify) ____

___ The following information should ***not*** be released (Please Specify) ____

Purpose of the use or disclosure: ____ Moving _____ Patient's Request ____ Physician/Staff Request Other:___________________________

_____ Transferring to another Provider, If so, Please state your reason why:____

Section B: (Must be completed only if the healthcare provider has requested the authorization)
The Provider must complete the following statement:
Will the healthcare provider requesting the authorization receive financial compensation in exchange for disclosing the health information described above:
YES _____ NO______ (ie Third Party Insurance Carrier request)

Section C: (Must be completed for all authorizations)
I understand that:

- I may revoke this authorization at any time by notifying the Practice's HIPAA Privacy Officer in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively.
- I may request or copy the protected health information to be used or disclosed.
- This authorization will expire one year from today's date unless otherwise specified.
- Jeffers and Mann Pediatric and Adolescent Medicine, P.A. assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization.

Patient/Parent/Guardian Signature: ____ Date: ____/_____/_____

Office Use Only: Patient Chart # _____________ Date Information Disclosed: _____/_____/_____ Initials _________

HIPAA Officer review (If records are being inspected by patient/parent) ____________________ Date Reviewed: _____/_____/_____
Updated 5/17/05
Updated 8/18/06