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

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Holly Springs, NC 27540
(919) 586-0050 Fax (919) 586-0055

West Cary
5029 Arco Street
Cary, NC 27519
(919) 388-7520 Fax (919) 388-7521

Authorization to Use/Release/Disclose Health Information

Please allow up to 30 days for completion of records.

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:** ____/____/_____

Address: _____ **Home Phone:**_____

_____ **Cell Phone:**_____

Persons/Organizations Providing the Information:

Name:_____

Address:_____

_____

Phone/Fax:_____

Persons/Organizations receiving the information:

Name:_____

Address:_____

_____

Phone/Fax:_____

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

___ Complete Jeffers, Mann and Artman Pediatrics Medical Records Paper Copy of Chart – **Charge $15.00** payable at time of request

___ Complete Jeffers, Mann and Artman Pediatrics Medical Records on Jeffers, Mann and Artman **USB** Drive – **Charge $15.00** payable at time of request

___ Copies of information described below for the Period ____/____/____ to ____/____/____ – **Charge $10.00** if greater than 14 pages
Mo Day Year Mo Day Year

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

___ 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, including Psychotherapy Notes, ADD / ADHD, etc) _____

Purpose of the use or disclosure: ____ Moving out of area _____ 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: _____ **Relationship:**_____ **Date:** ____/____/_____

Office Use Only:

HIPAA Officer review (If records are being inspected by patient/parent) _____ Date Reviewed: _____/_____/____

Records Received by:

Name:_____ **Signature:** _____ **Date:** ____/____/_____
Date Information Disclosed: _____/_____/_____ Jeffers Mann and Artman Pediatrics Representative _____

Updated 3/4/2021