JMA Pediatrics
Jeffers, Mann & Artman

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:**___/___/___ **Primary Contact #** _____
Address: _____ **Secondary Contact#** _____
_____

Persons/Organizations Providing the Information:
Name:_____
Address:_____
_____
Phone/Fax: _____

Person/Organization Receiving the Information:
Name:_____
Address:_____
Phone/Fax:_____

Under the age of "2"
Newborn Screening Information:
State baby born at: _____
Mothers Full name at baby's birth: _____
_____
Name of Hospital baby born at:
Mother's Maiden Name:_____
Newborn Hearing Screen:
____**Pass** ____**Failed**

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 Physcians

___ 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 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:

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

_____ **Updated 5/17/05 /Updated 8/18/06 /Updated 11/7/11 /Updated 8/20/2012/Updated 8/28/2012 / 10/21/2013 / 2/10/2014 / 2/3/2017/ 1/3/2018/Updated 3/19/2025**