



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

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: _____
Transferring back into JMA Pediatrics. If so, please state your reason why: _____

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)

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: ____/____/____ JMA Pediatrics Representative _____