we give a hoot!

460 Alabama Hwy 75 N, Albertville, AL 35951
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AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Patient Name (Last)	(First)	(MI)
Date of Birth	Social Security Number	
Street Address	City, State	Zip

I, the undersigned, do hereby authorize Smart Start Pediatrics LLC

☐ to release the above named patient's PHI to: ☐ to receive the above named patient's PHI from:

_____

(Agency/Facility/Person authorized to receive/release PHI)

_____

(Street Address) (City/State) (Zip)

_____

(Phone Number) (Fax Number)

Reason for transfer or release of PHI:

☐ Insurance Change ☐ Continuity of Care ☐ Legal
☐ Moving out of area ☐ Specialty Consultation ☐ At the request of the individual

Specific PHI to be transferred or released:

☐ Immunization Records ☐ Entire Medical Record ☐ Lab/X-ray (specify): _____

☐ Specific dates of service or date range: _____

☐ Other: _____

I understand that the patient's medical treatment record may include information pertaining to drug or alcohol abuse, sexually transmitted diseases, and psychological or psychiatric treatment unless I specify that the following information should NOT be released:

_____ _____

Specific information NOT to be released INITIALS

There is a fee to release medical records to a legal parent or guardian. Per state law, you may be charged up to $1.00 for each page of the first 25 pages and $0.50 for each page thereafter

I understand that:

1. Authorizing this release of information is voluntary and I may refuse to sign this authorization.
2. My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing this authorization.
3. I may revoke this authorization, in writing, at any time, except to the extent that action has been taken in reliance upon it.
4. The information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations.
5. I have a right to receive a copy of this request.

This **authorization will expire** on the following date or event: _____ or two years from the date signed.

Smart Start Pediatrics, its employees, and healthcare providers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____

Patient/Parent/Legal Guardian Signature Relationship to Patient Date

_____ _____

Print Name of Patient/Parent/Legal Guardian SSP Witness Signature

NOTE: Guardians & Durable Power of Attorney designees should include a copy of the applicable paperwork.