



Hometown Pediatrics

22136 Medical Village Drive
Athens, AL 35613
(P) 256.648.5598 (F) 833.603.1295

Authorization to Release Protected Health Information

Patient Name (Last)	(First)	(MI)
Date of Birth	Phone Number	

☐ I, the undersigned, do hereby authorize Hometown Pediatrics, LLC to **receive** the above-named patient's PHI **FROM**:

☐ I, the undersigned, do hereby authorize Hometown Pediatrics, LLC to **release** the above-named patient's PHI **TO**:

Facility & Provider		
Street Address	City/State	Zip
Phone Number	Fax Number	

Reason for transfer or release of PHI:

- | | | | |
|---|---|---|--------------------------------|
| ☐ Insurance Change | ☐ Transfer of Care | ☐ Continuity of Care | ☐ Legal |
| ☐ Moving Out of Area | ☐ Specialty Consultation | ☐ Personal | |

Specific PHI to be transferred or released:

- ☐ Entire Medical Record ☐ Most Recent Well Child Check & Shot Record ☐ Other: _____

I understand that the patient's entire medical treatment record, including information pertaining to drug or alcohol abuse and psychological or psychiatric treatment, will be provided unless I specify that the following information should NOT be released:

Specific Information NOT to be released

Signature

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, \$0.50 for each page in excess of 25 pages, and a search fee of \$5.00 for each patient health record requested.

Release or transfer of the specified information to any person or entity not specified above is prohibited. I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and mail my written revocation by certified mail, return receipt requested to the Privacy Officer at Hometown Pediatrics. I understand the revocation will not apply to information that has already been released in response to this authorization. I also understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that once this health care information is released, redisclosure of it by the recipient may no longer be protected by law.

This authorization is valid until ____ or two years from the date signed. Only the records from the facility/provider listed above can legally be released. Any record from another physician must be obtained from them.

I understand I have a right to receive a copy of this request.

Patient/Parent/Legal Guardian Printed

Patient/Parent/Legal Guardian Signature

Date

Witness Signature

Date