AVON PEDIATRICS

Release of Information

REQUESTING MEDICAL RECORDS FROM THE FOLLOWING FACILITY/OFFICE:

MEDICAL RECORDS WILL BE RELEASED TO:
Avon Pediatrics
7376 Business Center Drive Suite A
Avon IN 46123
Phone: 317-272-7887
Fax: 317-353-3502

PATIENT INFORMATION:

Patient Name (please print):_____

Patient Address: _____

****If moving, please list new address and phone#_____

Date of Birth: _____ Patient Telephone: _____

Covering the period(s) of treatment: _____

PURPOSE OF DISCLOSURE: _____

INFORMATION BEING REQUESTED:
_____ Complete copy of Medical Records _____ Vaccine record

_____ History & Physical

_____ Lab Results

I understand that visit notes may include use of tobacco and alcohol, depression, ADD/ADHD etc.

We are requesting this information for continuity of care for the patient listed above. This request is in compliance with 45 CFR 164 of the Health Insurance Portability and Accountability ACT (HIPAA) which allows release of information without explicit patient consent for treatment, payment and healthcare operations. I understand that the release of records also pertains to those regarding testing and treatment for alcohol/substance abuse, human immunodeficiency virus (HIV) and or AIDS, and for psychiatric treatment or counseling or communicable disease, unless I limit any of that information; please list

_____

_____

Your signature indicates that you have read and understand this form, and you authorize release of your information as described above. This authorization will expire 60 days from date signed unless otherwise specified. This request may be revoked by patient at any time by communicating in writing that intent to provider. I understand that the information used or disclosed may be subject to redisclosure by person (s) receiving it and no longer protected by federal privacy regulations.

SIGNATURE OF PERSON REQUESTING & Their Relationship to Patient:
_____
Parent/Legal Guardian/18yrs & over Patients

PRINTED NAME _____

DATE: _____