



AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize MVPediatrics to release protected health information, including copies of the medical record of the patient named below, to the following individual or organization named below. Disclosure may be by handwritten, electronic or verbal exchange.

Patient Name:	Date of Birth:	MRN:
Address (Street, City, State, Zip Code):	Telephone Number:	
<p>This information may be disclosed to and used by the following individual or organization: Name: _____ Address: _____ Telephone: _____ Fax: _____</p>		
<p>Purpose of Release: <input type="checkbox"/> Medical Care <input type="checkbox"/> Coordination of Care <input type="checkbox"/> Legal <input type="checkbox"/> Personal <input type="checkbox"/> Insurance <input type="checkbox"/> Disability <input type="checkbox"/> Leaving MVP* <input type="checkbox"/> Other: _____</p> <p><i>*If leaving MVPediatrics, please check the reason(s):</i> <input type="checkbox"/> Insurance Change (Please specify new insurance): _____ <input type="checkbox"/> Moved or planning to move <input type="checkbox"/> Location – prefer to be closer to work/home <input type="checkbox"/> My provider left <input type="checkbox"/> Unable to get appointment <input type="checkbox"/> Dissatisfied with care/service received (please explain below) <input type="checkbox"/> Unable to obtain referral to preferred specialist <input type="checkbox"/> Other: _____</p>		
<p>Treatment Dates: <input type="checkbox"/> All Dates <input type="checkbox"/> Specific Dates: _____</p>		
<p>Release of Information Requiring Specific Consent: The following categories of information may be included in your medical record and WILL NOT be released unless you indicate your specific authorization by INITIALING each appropriate category.</p> <p>_____ Genetic Testing _____ Sexually Transmitted Diseases _____ Abortion _____ Sexual Assault _____ Behavioral/Mental Health _____ HIV Information _____ AIDS or AIDS Related Condition _____ Domestic Violence _____ Alcohol or Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2</p>		
<p>Information to be released (please check all categories):</p> <p><input type="checkbox"/> Office Visits <input type="checkbox"/> Laboratory Results (including drug screenings) <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Behavioral Health Records <input type="checkbox"/> Billing Records <input type="checkbox"/> Complete Medical Record <input type="checkbox"/> Other: _____ <input type="checkbox"/> Disclose only the specific information listed: _____ (Clients initials) _____</p>		

OTHER IMPORTANT INFORMATION

- 1. I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment or eligibility for benefits will not be affected.
- 2. I understand that the Provider of the information disclosed cannot guarantee that the Recipient will not disclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information.
- 3. I understand that I may revoke this authorization in writing at any time, except that the revocation will not have any effect on any action taken by the Provider before the Provider received written notice of revocation.
- 4. Unless otherwise revoked, this authorization will expire on the following date, event, or condition or within one year: _____

Signature of Patient or Legal Guardian: _____

Date: _____

If signed by Legal Guardian, Relationship to Patient: _____

How would you like to receive this information?

- I will pick up in office MVPediatrics will mail to my home
- MVPediatrics will mail to other individual or organization

Office Use Only

Information sent: _____

Date: _____ By: _____

Original copy of release to patient's medical record; copy to requester

