MVPediatrics
Health and Wellness Center

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:**	

This information may be disclosed to and used by the following individual or organization:
Name: _____
Address: _____
Telephone: _____ Fax: _____

Purpose of Release: ☐ Medical Care ☐ Coordination of Care ☐ Legal ☐ Personal ☐ Insurance ☐ Disability ☐ Leaving MVP* ☐ Other: _____

**If leaving MVPediatrics, please check the reason(s):*
☐ Insurance Change (Please specify new insurance): _____
☐ Moved or planning to move ☐Location – prefer to be closer to work/home ☐ My provider left
☐ Unable to get appointment ☐ Dissatisfied with care/service received (please explain below)
☐ Unable to obtain referral to preferred specialist ☐ Other: _____

Treatment Dates: ☐ All Dates ☐ Specific Dates: _____

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.
_____ 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

Information to be released (please check all categories):

☐ Office Visits
☐ Laboratory Results (including drug screenings)
☐ Radiology Reports
☐ Behavioral Health Records
☐ Billing Records
☐ Complete Medical Record
☐ Other: _____
☐ Disclose **only** the specific information listed: _____
_____ (Clients initials) _____

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?

This request may take up to 30 days to process. If you are leaving the practice, you will need to identify a new healthcare provider; we will continue to oversee healthcare for you/your child for 30 days from the date of this request, but not beyond that date.

There is a $25 processing fee per child for paper records to be sent from this office. A $15 processing fee per child for records on a flash drive to be sent from this office. Payment must accompany this form. Any unpaid balances must be addressed.

☐ Paper record ☐ Record on flash drive

☐ I will pick up in office ☐ MVPediatrics will mail to my home (postage additional)
☐ MVPediatrics will mail to other provider or organization (no fee to send to another provider)

Office Use Only
Information sent: _____
Date: _____ By: _____

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

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