Release of Medical Information – Healthy Horizons Pediatrics

3741 Rome Dr. Ste. B Lafayette, IN 47905. Phone: 765-607-6160; Fax: 765-607-6161 www.healthyhorizonspeds.com

DATE: _____

Please check one of the following options:

- ❑ I hereby authorize Healthy Horizons Pediatrics to ***release*** the following information from the medical record(s) of:
- ❑ I hereby authorize Healthy Horizons Pediatrics to ***request*** the following information from the medical record(s) of:

NAME_____ Date of Birth_____

ADDRESS_____

CITY _____ STATE_____ ZIP_____

PHONE NUMBER _____ SOCIAL SECURITY NUMBER _____

Information to be released: **ALL** or Specific Dates_____
_____Notes from Office Visit
_____Immunization Records
_____Other-Please List _____

Records are to be:
- ❑ Requested from
- ❑ Sent to

NAME_____

COMPANY_____

ADDRESS_____

CITY _____STATE_____ZIP_____

PHONE _____ FAX _____

Purpose of Disclosure:
___Attorney/Legal
___Continued Patient Care
___Personal Use
___Commercial Insurance
___Other (Specify)

_____
_____
_____

I understand that such medical records may contain information regarding psychological, drug, and /or alcohol conditions, and /or diagnosis, treatment and care of sexually transmitted diseases or complications related to sexually transmitted diseases, including but not limited to HIV testing and results. I hereby authorize the release of such medical records pursuant to this authorization for release or request of medical records, and waiver confidentiality provisions pertaining to this release. I understand letters, correspondences, and copies of medical records from other health care providers will not be released.

Specification of the date, event, or condition upon which this consent expires: I understand that this consent is revocable, except to the extent that action has already been taken in reliance thereof. Request for revocation of this authorization must be in writing and presented to the Medical Records representative of Healthy Horizons Pediatrics. This authorization will expire (i) after six months, (ii) after the disclosure is made, or (iii) the date specified here:_____to accomplish the purpose of the disclosure stated above

The employees and physicians are hereby released from any legal responsibility or liability for the release or request of the above information to the extent indicated and authorized herein. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected under Title 45, CFR. Healthy Horizons Pediatrics may not condition treatment or payment on whether you sign this authorization. I understand that authorizing this disclosure of health information is voluntary.

Signature of Parent/Legal Guardian_____ Date_____

If Legal Representative, State Relationship_____

Patient Unable to Sign_____Reason_____

Witnessed by_____ Date_____