

GULF COAST CHILDREN'S CLINIC

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AUTHORIZATION FOR RELEASE OF RECORDS

Patient Name _____ DOB _____

Address _____ Phone _____

City _____ State _____ Zip _____

****Please choose Option 1 or Option 2 and complete the appropriate box. DISK COPY IS \$25 EMAIL FREE**

***OPTION 1: RECEIVE FROM another physician TO Gulf Coast Children's Clinic**

Sending Physician, please release my child's health information to Gulf Coast Children's Clinic.

Sending Physician Name: _____

Street: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

***OPTION 2: SEND FROM Gulf Coast Children's Clinic to another physician, parent, legal guardian or self**

Gulf Coast Children's Clinic, please release my child's protected health information to the following :

Receiving Physician/ parent, legal guardian or self Name: _____

Street: _____

City: _____ **State:** _____ **Zip:** _____

Email _____ **Phone:** _____ **Fax:** _____

Please release the following: _____ All Records (or check the following that apply)

_____ Progress Notes _____ Immunization Record _____ Problem List _____ Medication List _____ Chart Summary

****The PURPOSE OF DISCLOSURE :**

PROTECTED or SENSITIVE information: I understand that certain information cannot be released without specific authorization as required by State/Federal law. **BY INITIALING**, I authorize the release of the following protected or sensitive information.

_____ Mental Health ADD/ADHD _____ Sexually Transmitted Diseases _____ Drug Abuse/Treatment

_____ Alcoholism Diagnosis/Treatment _____ AIDS/HIV Results/High Risk Behavior _____ Genetic Testing

By signing this form, you are authorizing the use or disclosure of your protected health information as described above. This information may be redisclosed if the recipient is not required by law to protect the privacy of information.

You have the right to revoke this authorization at any time. If you revoke your authorization, the information described above may no longer be used or disclosed. The request to revoke must be in writing and must be received prior to release of information. Unless otherwise revoked, this authorization will expire 10 days from the date of signing.

You are under no obligation to sign this form, and you may refuse to do so. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except for obtaining information in connection with eligibility or enrollment in a health plan

Person Relationship to Patient Date Patient or Legally Responsible