MAIN STREET PEDIATRICS

Authorization to Use and Disclose Protected Health Information

Patient's Name:_____ Date of Birth: _____-_____-_____
Address: _____
Parent/Legal Guardian Name: _____
Daytime Phone #:_____

I authorize Main Street Medical Clinic LLC to request/release my child's protected health information (PHI) from/to the listed organization below:

Person / Organization information: (TO BE FILLED OUT BY PHYSICIAN OFFICE)
Name: _____
Address: _____
City, State, Zip: _____
Phone #:_____ Fax #: _____

Specific Information Requested:

Dates of treatment: from: _____to: _____

____ History & Physical
____ Immunization Records
____ Progress Notes
____ ADHD Evaluation
____ Entire Record
____ Labs
____ Radiology Reports
____ Pathology Report
____ Allergy Records
____ Sports Physical Evaluation
____ Other, specify_____

By initialing next to a category listed below, I specifically authorize Main Street Medical to use and/or disclose my highly confidential information. **Initial each category that Main Street Medical is authorized to release.**

_____Mental Health / Psychiatric / Psychological Records
_____Alcohol and/or Drug Abuse Records
_____Information about sexually transmitted diseases
_____HIV/AIDS related testing (whether the results were positive or negative)

_____The purpose for the use/disclosure of the information is:
_____Patient/Personal Representative request
_____Physician care
_____Educational Placement/Other Educational Concerns
_____Other, specify: _____
_____Legal
_____Insurance

Unless otherwise revoked, this Authorization will expire: One (1) year from signature date

I understand that once Main Street Medical discloses my PHI to the recipient, Main Street Medical cannot guarantee that the recipient will not redisclose my PHI to a third party. The third party may not be required to abide by this Authorization or applicable federal and state Privacy law governing the use and disclosure of my PHI.

I understand that according to state and federal law I may be charged a reasonable fee by the releasing facility for the photocopying of the requested records. I understand that Main Street Medical may directly or indirectly receive remuneration from a third party in connection with the use or disclosure of my PHI.

I understand that I may refuse to sign or may revoke (at any time) this Authorization and for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Main Street Medical; except, however if my treatment at Main Street Medical is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Main Street Medical may refuse to treat me if I do not sign this Authorization.

I understand that if I revoke this Authorization, I must send a written notice of revocation to the Custodian of Records at the address listed below. The revocation will be effective immediately upon Main Street Medical's receipt of my written notice. I understand that the revocation will not apply to information that has already been released in response to this Authorization.

I may contact the HIM/Custodian of Records at the address and phone/fax listed below

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I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my PHI. By my signature, I hereby, knowingly, and voluntarily authorize Main Street Medical to use or disclose my PHI in the manner described above.

_____ _____

Signature of Patient or Legal Representative **Date**

_____ _____

If signed by Legal Representative, Relationship to Patient **Signature of Witness** **Date**

· Please fill out the authorization completely. If sections are blank or incomplete, we may not be able to process your request.
. When submitting your request for medical records, please enclose a copy of your Photo ID.
Drivers License ___ Work Photo ID___ SS Card ___ Other Photo ID___ Notarized signature ____ Other___
· If the records are for a patient whom you have Power of Attorney, please enclose a copy of the POA.
. If the records are for a deceased patient, please provide a copy of the Executor of Estate or Death Certificate.

Completed Authorizations and any required paperwork can be mailed to:

Main Street Medical Clinic, LLC
1508 Cogswell Avenue
Pell City, Al 35125
Phone: 205.338.7866
Fax: 205.778.4318