PEDIATRIC ASSOCIATES
1000 East Primrose Street, Suite 560, Springfield, MO 65807 * 417-882-1600
Fax #: 417-631-0119

AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL INFORMATION

CCD or CCR Electronic copies are our preferred format for records if available

Patients Name (print): _____

Date of Birth: _____ Social Security Number: _____

Phone (home): _____ Parent's Name and work number_____

Address: _____

City: _____ State:_____ Zip:_____

I, the undersigned, authorize and request Pediatric Associates to:
_____ Release information to Obtain information from:_____

Physician / Person: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone: _____ Fax: _____

Reason for Release of Records: _____

Please release the following information for care / treatment received from dates of service _____ through _____

_____ Complete Record _____ Lab Results _____ Immunizations
_____ Progress Notes _____ X-Ray Results ____ Other(please explain below)
_____

DRUG AND/OR ALCOHOL ABUSE, AND /OR PSYCHIATRIC, AND/OR HIV/AIDS RECORDS RELEASE: This information may concern alcohol or drug abuse, psychiatric treatment, or HIV/AIDS testing and treatment. I agree to its release.

TIME LIMIT AND RIGHT TO REVOKE AUTHORIZATION: This authorization is effective for no longer than 90 days from the date on which it is signed. I understand this authorization can be revoked at any time, except to the extent that disclosure made in good faith has already occurred in reliance on this consent. I hereby release any person, agency, facility, or organization from any liability or legal responsibility for information furnished pursuant to this authorization. I also understand that failure to sign this authorization will result in no information being released.

Signed: _____ Date: _____

Relationship to patient: _____

Witness: _____ Date: _____

Re-disclosure: I understand that once information is released to the above named person or persons, any information may be subject to re-disclosure. I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless it is for research-related treatments or provided solely to give the information to a third party as specified under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. I authorize Pediatric Associates to use and disclose the protected health information specified above.

I understand that if I authorize the release of Drug & Alcohol Abuse treatment records (such as from center for Addictions) that those records are protected by Federal Law. The Authorization for release of information form does not authorize redisclosure of medical information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, prohibit information disclosed from records protected by this law from being redisclosed, even to the patient, without the specific written consent of the patient or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient for these purposes. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patients.