PEDIATRIC ASSOCIATES OF SPRINGFIELD, INC.
1000 E. PRIMROSE SUITE 560
SPRINGFIELD, MO 65807
PHONE (417) 882-1600
FAX (417) 631-0119

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please read carefully before signing and dating. All sections must be complete to be HIPAA compliant.

(1) Patient Name:_____ Birthdate: _____
(PLEASE PRINT) LAST FIRST M.I.

Have you ever used another name (maiden, adopted, nickname, etc.)? ☐ No ☐ Yes_____

Address:_____

Primary Phone #: _____ Alternate Phone #:_____

(2) **INFORMATION TO BE RELEASED *BY*:** INDICATE SPECIFIC CLINIC OR PROVIDER	(3) **INFORMATION TO BE RELEASED *TO*:** REQUEST MUST HAVE COMPLETE ADDRESS
_____ ORGANIZATION, CLINIC, OR PROVIDER	_____ ORGANIZATION, CLINIC, OR PROVIDER
_____ STREET ADDRESS	_____ STREET ADDRESS
_____ CITY, STATE, ZIP	_____ CITY, STATE, ZIP
_____ PHONE FAX	_____ PHONE FAX

(4) **INFORMATION AUTHORIZED TO RELEASE:**

☐ Complete record (includes but is not limited to: office notes, immunization record, growth charts)

☐ Lab Results ☐ Diagnostic Imaging Reports ☐ Immunization Record

☐ Other (please explain):_____

Release for the following dates:

☐ All Dates ☐ Specific Dates: _____ through_____

(5) **REASON FOR RELEASE OF RECORDS**: _____

(6) **By signing this Authorization form, I understand that**:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time, except when the named provider/organization has already acted in reliance on my authorization. Revocation must be made in writing to the health information department of the releasing entity.
- Unless otherwise revoked this authorization will be valid for 90 days from the date it is signed.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether or not I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
- Information disclosed may contain information about alcohol/drug abuse, sexually transmitted diseases, HIV/AIDS, genetics, or self-paid services.

LEGAL SIGNATURE:_____ DATE:_____
Parent/Legal Guardian must sign if patient is a minor, under 18 years of age

PRINTED NAME:_____

RELATIONSHIP TO PATIENT (if patient is a minor):_____