PHYSICIANS TO CHILDREN, INC.
21 Highland Avenue, SE, Suite 100
Roanoke, Virginia 24013

Telephone: (540) 344-9213
Fax: (540) 345-7559

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable/protected health information (PHI) as described below. I understand that the information I am authorizing to be disclosed may be subject to re-disclosure by the recipient and no longer be protected by federal privacy regulations.

If transferring records to PTC, please include updated phone number, vaccine record, most recent wellness exam, and birth history

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Persons/organizations providing information
(Name of Practice/Phone/Fax/Address)

_____
_____

Person/organizations receiving information
(Name of Practice/Phone/Fax/Address)

_____
_____

Patient's name:_____ **Date of Birth**:_____

Specific description of information to be released/copied including date(s):

_____
_____

Purpose of the use/disclosure: *please check* √

( ) Personal copy ( ) Over age 22 ( ) Insurance change ( ) Moving ( ) Doctor closer to home
( ) Going to Family Doctor ( ) Referral to specialist ( ) Other_____
( ) Dissatisfied with Physicians to Children (please state why)_____

The patient or the patient's representative must read and initial the following statements:

a) I understand that my health care and the payment for my health care will not be affected if I do not sign this form. **Initials_____**

b) I understand that I get a copy of this form after I sign it. **Initials_____**

c) I understand that this authorization will expire on ___ /___ /_____ (1 year from date signed) or upon the event of_____ or if revoked in writing. **Initials_____**

d) I understand that I may revoke this authorization at any time by notifying the Privacy Officer at Physicians to Children in writing, but if I do, it will not have any effect on actions Physicians to Children took before it received the revocation. **Initials_____**

e) I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the costs of supplies and labor and postage related to the production of my information. I understand that the charge for this service is **$.50** per page up to 50 pages; **$.25** per page for 51 pages and up. **Initials_____** **(Immunization record and/or copies of the last 2 physicals – NO CHARGE).**

THE REQUESTED PHI WILL BE RELEASED WITHIN 15 DAYS OF THE RECEIPT OF THIS SIGNED FORM

Signature of patient or representative _____ **Date**_____

Printed name of patient or representative _____

Relationship to the patient _____ **Daytime Phone:** _____

Insurance Information: (Please specify) _____