**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.

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

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

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

**Specific description of information to be released/copied including date(s):**
**(Immunization record and/or copies of the last 2 physicals – NO CHARGE).**

_____

*****IF Patient is transferring to Physicians to Children – Birth Records must be included in records.*****

**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's representative** _____

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

**Insurance Information: (Please specify)** _____