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) _____