AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (For Patients 18+)

Please note that a fee may be associated with providing a copy of your medical record. Updated 5/2023

Patient's Name: ______________________________ Date of Birth: ________________
MM/DD/YYYY

Previous Name: ____________________ Patient's Phone#: ______________________

I authorize The Kids Clinic (TKC) to release the following health care information (check all that apply):

☐ All health care information in the patient's medical record ☐ Immunization Record Only
☐ Information in the record relating to the following treatment or condition: ____________________
☐ Information in the record for the date(s): ______________________________
☐ Other –specify: ______________________________

You MUST initial each topic. If there are no initials, records containing these specific topics will *NOT* be included.

You may release health care information regarding testing, diagnosis, and treatment for (initial all that apply):

HIV/AIDS ________ Sexually transmitted diseases ________ Mental health or illness ________ Drug and/or alcohol abuse ________

I request and authorize **The Kids Clinic** to release health care information about the patient named above **TO:**

Person or Facility Name: ______________________________

Check next to which option and provide the necessary information.

☐ **MAIL Records TO (Paper or CD/Flash drive):**

Address: ______________________________

City: ____________________ State: __________ Zip: __________

Phone#: (   ) ____________________

☐ **FAX Records TO (will fax if 10 pages or less):**

Fax#:(   ) ____________________ Attention: ____________________

☐ **EMAIL Records TO** (*Email will come via a secure, encrypted email from Proton Mail*):

Email: ______________________________

The purpose for the release of information:

☐ Attorney ☐ Insurance (any type) ☐ Doctor (Transferring care: ☐ yes or ☐no ☐ Personal

☐ School/Daycare ☐ Other: ____________________

This Authorization Ends (check one):

☐ On (specific date): ____________________ Or when the disclosure occurs ☐ __________ (initial)
Neither event can be longer than 6 months from the date signed. If not specified, authorization will expire 6 months from the date signed.

My Rights:
I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment).
I may revoke this authorization in writing. I understand that once The Kids Clinic discloses health care information, the person or organization that receives it may re-disclose it, at which time it may no longer be protected under privacy laws, and The Kids Clinic is not liable for any further disclosure of your healthcare information.

____

Patient signature Date Time

SELF
____

Printed name Relationship