Clear Form

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

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

Patient's Legal Name: _____
First Last

Date of Birth: _____ Previous Name: _____ Phone#: _____
MM/DD/YYYY

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: _____

13-17-year-olds MUST initial each topic. If there are no initials, records containing these topics will NOT be included in the release.

The Kids Clinic 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 _____

13-17-year-olds MUST sign this release for it to be processed.

A minor's signature is required at any age if their healthcare records contain information related to birth control.

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#:( ) _____

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

Email: _____

The purpose for releasing records:

☐ Attorney ☐ Insurance (any type) ☐ Doctor (Transferring care: ☐ yes or ☐no) If yes, why _____

☐ Personal ☐ School/Daycare ☐ Other: _____

This Authorization Ends (check one):

☐ On (specific date): _____ Or when the release 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.

_____
Legal Guardian signature Date Time

_____
Printed name Relationship (parent, legal guardian, personal representative)

_____
Patient's signature if 13-17 years old or if otherwise applicable (see above box) Date Time

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