Authorization for Release of Medical Information

Poplar Bluff Pediatric Associates, LLC
2210 Barron Road, Suite 120
Poplar Bluff, MO 63901
Telephone (573) 785-2005 Fax (573) 785-9444

I, voluntarily give my authorization to use or disclose my protected health information (PHI) on

Patient's Name: _____ Date of Birth: _____

Address: _____ City/State: _____

Zip Code: _____ Telephone Number: _____

Reason for Release

- ☐ Transfer of care due to _____
- ☐ Send to Specialist
- ☐ Personal Use
- ☐ Other (specify) _____

☐ SEND TO: _____ ☐ REQUEST FROM: _____

_____
Physician Name/ Office Name

_____ _____
Street Address, City, State, Zip Code Phone Number

☐ I will **PICK UP** records at Poplar Bluff Pediatrics

☐ Please **FAX** records to _____(SHOT RECORDS ONLY) Attention: _____

☐ Please **MAIL** records to address listed. Attention:_____

Please check specified information requested: ☐ All Records ☐ All Labs ☐ School/Daycare Forms ☐ Shot Record

☐ Mental Health/Behavioral ☐ Other (specify) _____ Dates of Service Requested _____

I understand that my records may contain but are not limited to history, diagnosis, and/or treatment of HIV (AIDs Virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness, Psychiatric/Psychological conditions or genetic counseling. I give my specific authorizations for these records to be released. I understand that I may revoke this authorization at any time by giving written notice to Poplar Bluff Pediatrics. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy. Poplar Bluff Pediatrics takes necessary steps to protect our patient's private health information. I understand I may cancel this request with written notification; however, this would not affect information released prior to my cancellation request. The request for medical records is provided at no charge if requested by another doctor's office, however if requested by parent/guardian for personal use there is fee. I understand the requirements of this authorization release and voluntarily consent to the release of my record or my child's record to where I have indicated above. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected by Federal Privacy Rules. Medical Records may take up to 30 business days from the date of receipt to process your request. Please contact us if you have any questions regarding this authorization release form.

☐ ***Yes, I consent to the release of this information.*** ☐ ***No, I do not consent to the release of this information.***

You have a right to have a copy of this form after you sign it.

_____ _____ _____ _____
Print Parent or Guardian Name **Signature** of Parent or Guardian Relationship to Patient Date
(Or Signature of Patient if 18 years or older)

This authorization expires on: _____