MADISON VALLEY PEDIATRICS, P.C.
101 WESTOVER CIRCLE SUITE A
MADISON, AL 35758
PHONE: (256) 461-0209
FAX: (256) 325-3147

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the use or disclosure of my protected health information (PHI) as prescribed. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

Patient Name Date of Birth Sex Social Security Number

Address City State Zip

I hereby authorize Madison Valley Pediatrics, P.C. to ….
_____RELEASE TO: (and/or) ____OBTAIN FROM:

Name

Address City State Zip

THE FOLLOWING INFORMATION PERTAINING TO TREATMENT:

____Progress Notes ____History and Physical ____Lab
____Immunization Record ____Discharge Summary ____Pathology Report
____Referrals ____Imaging Report ____Other _____

PURPOSE FOR DISCLOSURE _____
_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services for alcohol and drug abuse. I understand that authorizing the disclosure is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.

REVOCATION: This authorization to release confidential information may be revoked by me, in writing, at any time, except to the extent that action has already been taken.

It is often necessary to release your health information via facsimile when it is needed for car. We confirm receipt of information when it is FAXED. I authorize transmission of my health records in situations where this information is needed for continuing care.

_____ _____ _____
Signature of Patient/Representative **Date** **Relationship to Patient**

(I understand that this authorization will automatically expire ninety (90) days from date signed)

_____ _____
Witness **Date**