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PLEASE RETURN TO: Vestavia Pediatrics, 1936 Old Orchard Road
 Birmingham, Alabama 35216
 PHONE: (205) 978-3200
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Children's Health System- Authorization for Release of Information

Patient Name (First, Last, MI): _____

Address: _____

Phone Number: () _____ Date of Birth: _____

This Authorization applies to the following information:

All information. I understand that the information may contain psychiatric/psychological, alcohol/drug abuse, and/or AIDS/HIV information and I expressly consent to the release of the information.

Only the following records or types of information: _____

Treatment Dates: from (month/day/year) ___/___/___ to (month/day/year) ___/___/___

The information may be released as follows:

(Please check FROM whom the information is released and TO whom it goes)

from **OR** To Children's Health System (Please provide address/phone #):

from **OR** To External Individual/Agency/Organization (Please provide address/phone #):

Purpose of the release:

Continuity of Treatment Other (Please specify): _____

I understand the information released will be limited to information necessary to fulfill the need or purpose for the disclosure. If I have authorized the disclosure of information to a recipient who is not subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), then the recipient may re-disclose it and it may no longer be protected under HIPAA, a federal privacy law. This Authorization is valid for ninety (90) days from the date of signature, unless otherwise noted. This Authorization only applies to treatment occurring before the date of signature. I may decline to sign this Authorization. I understand I may revoke this authorization in writing at any time by completing a form available from Vestavia Pediatrics. If I revoke this authorization, the revocation will not apply to information that has already been released in response to this authorization. I understand the patient's health care and the payment for the patient's health care will not be affected if I do not sign this form. I understand I may see and copy the information described on this form if I ask for it, and I may receive a copy of this form after I sign it. Before requesting medical record copies, please ask about the copy fee by law that may apply. I represent that I have the authority to and voluntarily grant permission for the information to be released as described above.

Parent/Legal Guardian Printed Name _____

Parent/Legal Guardian Signature _____ Date _____

Patient Signature if 14 or older _____ Date _____

Witness Signature for Patient/Parent/ Legal Guardian _____ Date _____