ELM Pediatrics

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Authorization for Release of Protected Health Information

I hereby authorize _____ to disclose/release protected health information

to _____ from the health records of:

Patient Name: _____

Address: _____

Date of Birth: _____ Phone: _____

This release of protected health information includes the following date(s):

From *(date)*: _____ To *(date)*: _____

Purpose of the release: _____

The following information may be released/disclosed: (check all that apply)

☐ Complete Health Record(s)
☐ X-Ray(s) & Reports
☐ Laboratory Tests
☐ History & Physical Examination
☐ Progress Notes
☐ Photographs, Videos (Digital or Other)
☐ Other: _____

1. *I understand that if my records contain documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable diseases, this information will be released as part of my record.*
2. *I understand that if the person or entity receiving this information is not covered by federal privacy regulations, this information will no longer be protected and may be re-disclosed.*
3. *I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released. Revocations should be sent to the address at the bottom of this form.*
4. *I understand that there may be a charge for obtaining the requested information. Information on the charge may be obtained by contacting ELM Pediatrics, LLC.*
5. *I understand that a copy or facsimile of this document is just as valid as the original document.*
6. *I understand that this authorization will expire in ninety (90) days after signed unless an earlier date is specified.*

_____	_____	_____	_____
Printed Name of Patient or Authorized Person	Signature of Patient or Authorized Person	Relationship to Patient	Date

_____

Address *(include city, state, and zip code)*

Phone: Cell _____ Home _____ Work _____

PROVIDER USE ONLY

Original Medical Records To: _____ *Copy To:* _____

Verification Completed By: _____ *Date:* _____

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