KIDS FIRST PEDIATRICS

For Office Use:
____ Initial Staff Intake

____ Records Exported (OG)
____ Records Reviewed (OG)

Revised 1/4/2016

Authorization to Release Medical Records and Protected Health Information

All information must be completed in full to validate this request. Copies of medical records from Kids First will be furnished using the HIPAA compliant and secure program ShareFile, through email only, and may take up to 3 business days. There is a $25 fee for Kids First medical records, due at time of request, except for the transfer to another licensed physician or for an agency administering disability or special benefits. Notary service is $6.

Releasing Records From:

Name:_____
Address:_____
_____
Phone:_____ Fax:_____
Email:_____

Releasing Records To:

Name:_____
Address:_____
_____
Phone:_____ Fax:_____
Email:_____

Patient Information:

Patient/Child #1 Name: _____ DOB: ____/____/____ Age: _____
Patient/Child #2 Name: _____ DOB: ____/____/____ Age: _____
Patient/Child #3 Name: _____ DOB: ____/____/____ Age: _____
Address: _____ Phone: _____
_____ Email: _____

Information to be covered by this release:

☐ Entire Record ☐ Lab/Pathology ☐ Radiology/X-ray ☐ Operative
☐ Newborn/Neonatal ☐ ER ☐ Labor & Delivery ☐ Immunizations
☐ Other _____

Note: The above information may include records we have on file from other physicians and/or health organizations.

Purpose for release:

☐ Relocating out of area ☐ New insurance not accepted ☐ Referral to specialist
☐ Legal proceedings ☐ Personal files ☐ Other _____

I, _____, authorize the above listed entity and its employees to release for inspection and copying the Protected Health Information (PHI) specified above. I understand the records may contain information of a sensitive and confidential nature including but not limited to mental health, AIDS/HIV test information, and drug or alcohol treatment. I understand I may revoke this release at any time by notifying Kids First in writing. I understand the potential for information to be disclosed following authorization is subject to redisclosure by the recipient and is no longer protected by HIPAA.

_____ _____
Parent/Guardian/Adult Patient's Signature Date

(PATIENTS 18 YEARS AND OLDER MUST SIGN FOR RECORDS TO BE RELEASED)