Gulf Coast Pediatrics

Authorization To Use Or Disclose Protected Health Information

Patient Name_____

Parent or Legal Guardian_____

Date of Birth____/____/____ Social Security #_____

I authorize _____

Address_____

Phone_____ Fax_____

At The Request of the Individual_____ Other Reason_____

To release the following:

Complete record_____ **OR**

Physician notes_____ Lab results_____ x-ray reports_____

Radiology Reports_____ cardiac reports_____ Immunization records_____ Treatment Dates_____

To _____Gulf Coast Pediatrics_____

Address_____5675 Three Notch Rd Suite C_____

Phone_____251-445-4440_____Fax_____251-445-4435_____

I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I understand that the revocation will not apply to information already released based on this authorization.

I understand that authorizing this disclosure is voluntary and that I may refuse to sign. I do not need to sign this form to assure treatment. I may inspect or obtain a copy of the information to be used or disclosed if I so desire.

Unless otherwise revoked, this authorization will expire one year from the following date.

Signature of Patient, Parent or Legal Guardian:

_____ Date_____

Signature of Witness:

_____ Date_____