

Gulf Coast Pediatrics

Authorization To Use Or Disclose Protected Health Information

Patient Name _____

Parent or Legal Guardian _____

Date of Birth ____/____/____ Social Security # _____

I authorize _____ Gulf Coast Pediatrics _____

Address _____ 5675 Three Notch Rd Suite C _____

Phone _____ 251-445-4440 _____ Fax _____ 251-445-4435 _____

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 _____

Address _____

Phone _____ Fax _____

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 _____