BOONSLICK PEDIATRICS, L.L.C.
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AUTHORIZATION FOR DISLOSURE OF HEALTH INFORMATION

(Complete question #1 with information about who is sending information to us, or if we are sending it to someone else we can stamp it with our data.)

1. I hereby authorize (name of provider)_____,(address)_____
_____,(telephone)_____,(fax)_____
to disclose the following information from the health records of:

Patient Name_____ Date of birth _____
Address_____ Telephone _____
_____

Covering the periods of healthcare

From (date)_____to (date)_____

2. Information to be disclosed: **(Check the boxes to indicate what information needs to be sent.)**
( ) Complete health records ( ) Progress notes
( ) History & physical examination ( ) Laboratory test
( ) Consultation reports ( ) X-ray records
( ) Photographs, videotapes, digital or other images
( ) Other (please specify)_____

(Complete question #3 with the information who the information is being sent to. If we are receiving the information we can stamp it with our data.)

3. This information is to be disclosed to:_____
Address_____City_____State_____Zip_____
Telephone _____ Fax _____

For the purpose of ( ) Changing Physician, ( ) Moving, ( ) Other_____

4. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in 90 days.
5. I understand that Boonslick Pediatrics, LLC cannot release records of my medical treatment, testing and/or procedure that were done at other healthcare facilities. I must request my records from those facilities separately.
6. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed:_____
(patient) (date)

_____
Or (legal representative) (relationship to patient) (date)

_____
(signature of witness) (date)

NOTICE TO PATIENT:
Information used or disclosed pursuant to an authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA final privacy rule.

Copies that are picked up by a patient are subject to a copy fee to be paid in advance. The copy chart fee is $24.57 plus $0.56 per page. An additional fee up to $23.00 will be charged if records are maintained off-site. These fees are subject to change.