South Summit Pediatrics
Dr. Paul Lei, M.D.

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Authorization for South Summit Pediatrics to Release Medical Information

Patient Name: _____
Date of Birth: _____
SSN: ____-____-____ Phone Number: _____

Authorization for South Summit pediatrics to release information for the above patient to:
Name of person(s) or facility_____
Address of the above: _____
Phone Number: (____) _____ Fax Number: (____) _____

Please release the following information:

___ Complete Medical Record
___ Most Recent Physical Exam
___ Immunization/TB Record Only
___ Specific Date of Service_____
___ Lab Results/ X-Ray Only
___ Other (specify) _____

Reason for Release: _____

I understand that information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and/or drug abuse. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. **If I fail to specify an expiration date, event, or condition this authorization will expire in (6) months.** Furthermore, I understand that there may be charge for copying of records.

This information is disclosed from records whose confidentiality is protected by Federal Law. Regulations (42 CFR Part II) prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization is not sufficient for this purpose.

I understand that under HIPAA regulations, South Summit Pediatrics cannot release any medical records that may have been released to South Summit by a previous provider.

Signature_____ Relationship to patient: _____
Date: _____

For Office Use Only:
Form Released By: _____
Signature: _____