☐ 8606 Village Drive, Suite A San Antonio, TX 78217 FAX (210)590-7288
☐ 18707 Hardy Oak Blvd., Ste 225 San Antonio, TX 78258 FAX (210)402-2868
☐ 5000 Schertz Parkway, Suite 202 Schertz, TX 78154 FAX (210)651-0483

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:	Date of Birth:
Address:	Phone Number:

INFORMATION TO BE RELEASED:	FROM:	TO:
☐ MAIL ☐ PICK-UP ☐ FAX ☐ OTHER: _____		

PLEASE CHECK TYPE OF INFORMATION TO BE RELEASED:

☐ All records last 2 years	☐ All records last _____ years	☐ X-ray reports
☐ Progress notes only	☐ Consultation reports only	☐ X-ray films/images
☐ Laboratory test results only	☐ Other (specify):	☐ Immunizations/Growth Chart

PURPOSE OF REQUEST:

☐ Change of physician	☐ Relocation/Moving	☐ Billing or claims payment
☐ Referral appointment	☐ Other (specify):	

DRUG, ALCOHOL, PSYCHIATRIC, AND HIV/AIDS INFORMATION

I understand that the requested information may contain reference to or results of HIV/AIDS testing and/or treatment, drug abuse, alcohol abuse, psychiatric care, sexually transmitted diseases, Hepatitis B or C testing, and/or other sensitive information. I authorize the release of such confidential information to the indicated party, unless prohibited in my instructions above.

TIME LIMIT AND RIGHT TO REVOKE AUTHORIZATION

I understand that I can at any time revoke this authorization in writing. I am fully aware that any action taken prior to receipt of this revocation, is in reliance with this original authorization. I will submit my notice in writing to the Privacy Officer at Northeast Pediatric Associates P.A., 8606 Village Drive, Suite A, San Antonio, TX 78217.

RE-DISCLOSURE STATEMENT:

I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA of 1996. The facility, its employees, representatives, 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.

FEE FOR COPYING REQUESTED INFORMATION: I understand that there will be a fee associated with the copying of the requested information, I have been notified of this policy and agree to pay accordingly. The fee is $25 for the first 20 pages and $0.50 for each additional page per medical record request. Please initial _____.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE WHO MAY REQUEST DISCLOSURE

I understand that I do not have to sign this authorization. My treatment or payment for services will not be denied if I do not sign this form, unless specified above under Purpose of Request. I can view or receive a copy of the Protected Health Information (PHI) to be used or disclosed. I authorize Northeast Pediatric Associates P.A., to use and disclose the PHI specified above.

PRINT PATIENT/PARENT NAME: _____ DATE: _____

PATIENT/PARENT SIGNATURE: _____

WITNESS PRINT NAME: _____ WITNESS SIGNATURE: _____

--OFFICE USE ONLY--

DATE RECEIVED:	NUMBER OF PAGES:	FEE:	PAID: CASH CREDIT CD # CHECK #	DATE COMPLETED:	INITIALS: