Rainbow Pediatric P.C.

Authorization for Release of Protected Health Information from Another Facility

Patient Name:	Birth Date:	SS No. (optional)
	Other Names Known By:	

Person/Organization Authorized to Disclose Protected Health Information:

Release Records to Rainbow Pediatric, P.C. Attention:	Address: 1636 Main Street Humboldt, TN 38343 Telephone: 731-784-7833 Fax: 731-784-7856

Purpose of Disclosure: _✓_ Medical Care ____Insurance _✓_ At the Request of the Patient
___ Media, Public Relations, Marketing, Advertising,Posting, or Radio Broadcasting
___Other, Please Explain:

Description of Information to be Used or Disclosed:

Dates of Treatment:	Place of Treatment:

Choose from the Following:

__All Dictated Reports	__Lab (may include AIDS/HIV Information		__History & Physical
__Radiology Reports	__Pertinent Summary	__Discharge Summary	__Pathology Reports
__ER Record	__Consultation	__Anesthesia Record	__Billing Record
__Operative/Procedure Report	__Entire Chart	__Photographs/Images	__Others (Specify):

I understand that:

1. I may revoke this authorization in writing at any time by notifying in writing the person/organization providing or disclosing the information. However, if I revoke this authorization, it will not have any effect on any action taken by the person/organization providing, disclosing, or receiving the information prior to receiving the revocation, nor shall it be valid to the extent that the disclosing person/organization or receiving organization has taken action in reliance on this authorization.

2. This authorization allows Rainbow Pediatric P.C. to obtain any and all documents in my medical record including those copies from other health care facilities and providers. I understand that the information that is released or provided may be re-disclosed and no longer protected by federal privacy regulations.

3. Any disclosure of records concerning diagnosis and/or treatment of alcohol and/or drug abuse is covered by Title 42 CFR, and if there is any such information, I hereby authorize the release of information. This authorization also includes any information related to diagnosis and/or treatment of any psychiatric or mental illness or any state of infection with the HIV (AIDS) virus.

4. Rainbow Pediatric P.C. is hereby released from any liability and the undersigned will hold Rainbow Pediatric P.C. harmless for requesting or seeking my protected health information.

5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal will affect my ability to obtain treatment, receive payment, or eligibility for benefits.

6. The authorization will expire in 12 months unless I provide an alternate date or event.

7. A facsimile of this authorization or a copy of this authorization shall be valid and binding with the same force as an original signature, and the person/organization releasing the information shall be entitled to rely on the same.

I have read and understood this authorization. I hereby authorize the release of the above-requested medical information about me to Rainbow Pediatric P.C. from the facility named above.

Signature of Patient/Authorized Rep________________________________ Date________________

Description of Rep's Authority____________________ Telephone Number________________________

Date Received____________ Date Scanned____________ Revised: 8/14/14