



MAIN STREET PEDIATRICS

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AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS (PHI – Protected Health Information)

There will be a \$10.00 per patient processing fee (\$40.00 maximum per family).
Under the privacy rule, medical practices may charge patients a fee for copying records.

Patient Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

City, State and Zip: _____

- Main Street Pediatrics is authorized to disclose medical records

Please Send Medical Records to:

Home/Physician/Clinic: _____

Street Address: _____

City, State and Zip: _____

Reason for leaving Main Street Pediatrics: _____

I hereby authorize release of this record to include information related to:

- Alcohol/drug use/abuse or treatment
- Treatment for Behavioral Health illness
- Treatment for sexually transmitted illnesses/venereal disease
- Treatment of HIV/AIDS

I understand that I have the right to revoke this authorization at any time and it must be done by submitting a written request to the office manager at Main Street Pediatrics. I understand that the revocation will not apply to information that has already been released. I understand that any disclosure of information carries with it the potential for redisclosure and the information may not be protected by federal confidentiality rules.

Parent/legal guardian signature: _____

If 18 years of age or older, signature: _____

Print name of parent/legal guardian/18+ adult: _____

Relationship to patient: _____ Date: _____