Twickenham Pediatrics, PC

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Authorization for Release of Medical Records

Please fill out one form for each child transferring into our office for each physician/clinic we need to request records from (pediatrician, allergist, ENT, etc.). This allows us to collect a complete record of your child's medical history. *Must be signed by patient if 16 years old or older by state law.*

PLEASE FILL THIS FORM OUT IN BLACK OR BLUE INK. PLEASE PRINT, NO CURSIVE. THANK YOU.

I authorize the following protected health information to be released from the medical record of: *(Child's information)*

LAST NAME _____ FIRST NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

HOME PHONE NUMBER _____ CELL PHONE NUMBER _____

If you would like records to be released to you, please provide your information instead of the physician/clinic information.
There is a $10.00 fee per child for medical records released directly to the parent.

RELEASE RECORDS	☐ From	☐ To	RELEASE RECORDS	☐ From	☐ To
Twickenham Pediatrics **115 Manning Dr. SW, Ste. A101** **Huntsville, AL 35801-4341** **Phone: (256) 533-1030 Fax: (256) 533-1043**			PHYSICIAN OR CLINIC NAME _____ ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____ PHONE _____ FAX _____		

Twickenham Pediatrics faxes all medical records via a VoIP line, if this is a problem for your office, please notify us.

TO BE RELEASED	DATE(S) OF SERVICE	TO BE RELEASED	DATE(S) OF SERVICE
If you are transferring care and are unsure of what to select, normally the best option is to request the entire medical record to provide the most information for the new physician.			
☐ Immunizations	_____	☐ Last Check-up	_____
☐ Entire record	_____		
☐ Other	_____ TYPE OF RECORD AND DATE(S) OF SERVICE		

REASON FOR RELEASE OF INFORMATION

☐ Transfer of care or Relocation
☐ Insurance (we do not accept Medicaid, TRICARE Prime, or Liberty Healthshare)
☐ Other (PLEASE SPECIFY) _____

☐
I understand that to the extent that any recipient of this information, as identified above, is not a "covered entity" under Federal or Alabama privacy laws, the information may no longer be protected by Federal and Alabama privacy laws once it is disclosed to the recipient and, therefore, may be subject to re-disclosure by the recipient.

I understand that this authorization is valid until I notify Twickenham Pediatrics otherwise. I may revoke this authorization in writing at any time except to the extent that Twickenham Pediatrics has already relied on this authorization. I may revoke it by mailing or faxing a written notice to Twickenham Pediatrics. I understand that the records released may include information relating to Human Immunodeficiency Virus (HIV) Infection or Acquired Immunodeficiency Syndrome (AIDS); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care. I understand my treatment will not be conditioned by my completion of this form. **I will be billed $10.00 for medical records that are given to me personally**, however if transferring care then records will be sent to the new physician at no cost.

SIGNATURE OF PATIENT, PARENT, OR LEDAL GAURDIAN _____ DATE _____