Twickenham Pediatrics, PC

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Authorization for Release of Medical Records

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

Please complete a separate Release of Information form for ***each child*** *transferring into our practice, and a separate form for each* ***physician or clinic*** *from whom we are requesting medical records (e.g., pediatrician, allergist, ENT). This process helps ensure we receive a* ***complete, accurate, and timely record*** *of your child's medical history.*

As a ***Patient-Centered Medical Home (PCMH),*** *Twickenham Pediatrics coordinates care across providers and settings and relies on complete prior records to support* ***comprehensive, coordinated, and patient-centered care.*** *Having these records allows our team to better understand your child's history, avoid unnecessary repeat testing, and provide the safest and most effective care possible.*

Under Alabama law (see Ala. Code Title 22, Title 1, Chapter 8, including §§ 22-8-4, 22-8-5, and related provisions), a minor's ability to consent to medical care and to authorize release of their own medical information is governed by state consent rules and may differ from parental authority. *With the recent changes to Alabama medical consent law, individuals age* ***16 years or older*** *are generally treated as capable of consenting to medical treatment and associated confidentiality decisions under state law, unless a specific exception applies.*

In accordance with the federal HIPAA Privacy Rule (45 C.F.R. § 164.508), a valid written authorization signed by the individual whose protected health information (PHI) is to be disclosed is required for disclosures outside of treatment, payment, and health care operations. *Unless state law specifically provides otherwise, a covered entity must obtain the patient's (or the patient's personal representative's) written authorization to release PHI.*

Therefore, ***if a patient is 16 years of age or older, the individual must personally sign the authorization form.*** *If the patient wishes for us to provide protected health information to a parent or another designated individual, the patient must specifically name that person on the form where indicated. This ensures compliance with both applicable Alabama consent law and federal HIPAA requirements.*

I authorize the release of the protected health information (PHI) described in this form from the medical record of the following patient: *(Child's information)*

LAST NAME _____ FIRST NAME _____ DATE OF BIRTH _____

If you would like your child's medical records released directly to you, please enter your name and contact information in the section designated for the receiving physician or clinic (in place of provider/facility details). Please note that when records are released directly to a parent/guardian, a $10.00 fee per child applies. ***Records are provided on a CD-R disk in .PDF format. If printed records are requested, the cost will depend on the total number of pages; a price quote will be provided for your final approval and must be paid prior to printing.***.

RELEASE RECORDS: □ From or □ To

Twickenham Pediatrics

115 Manning Dr. SW, Ste. A101

Huntsville, AL 35801-4341

Phone: (256) 533-1030 Fax: (256) 533-1043

RELEASE RECORDS: □ From or □ To

PHYSICIAN OR CLINIC NAME

ADDRESS

CITY STATE ZIP CODE

PHONE FAX

TO BE RELEASED:

If you are transferring care ***to another practice*** *and are unsure which records to request, please contact the receiving office to confirm* ***exactly what information they need****. This helps ensure we release* ***only the information necessary*** *for the purpose of the transfer, consistent with privacy standards.*
If you are transferring care ***into Twickenham Pediatrics****, please authorize release of the* ***complete medical record****. As a* ***Patient-Centered Medical Home (PCMH)****, we coordinate care across providers and rely on complete prior records to support* ***comprehensive, coordinated, and patient-centered*** *care.*

□ Immunizations

□ Last Check-up

□ Entire Record

□ Other _____
TYPE OF RECORD AND DATE(S) OF SERVICE

REASON FOR RELEASE OF INFORMATION:

□ Transfer of Care & Reason for Transfer _____

□ Relocation out of the Area

□ Insurance (we do not accept Medicaid, TRICARE Prime, or Liberty Healthshare)

□ Other (PLEASE SPECIFY) _____

I acknowledge that, ***if any recipient identified above is not a "covered entity" or "business associate" subject to the HIPAA Privacy Rule, the information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA*** *(45 C.F.R. § 164.508(c)(2)(iii)).*

I understand that ***this Authorization remains in effect until I revoke it in writing****. I may revoke this Authorization at any time by submitting a written revocation request to Twickenham Pediatrics (by mail or fax).* ***Revocation will not apply to the extent that Twickenham Pediatrics has already taken action in reliance on this Authorization*** *(45 C.F.R. § 164.508(b)(5)(i)), and this Authorization must include notice of my right to revoke and how to do so (45 C.F.R. § 164.508(c)(2)(i)).*

I understand that the records released may include ***any protected health information described in this Authorization****, which may include sensitive information such as HIV/AIDS information, substance use disorder treatment/history, and mental/behavioral health or psychiatric information (45 C.F.R. § 164.508(c)(1)(i)).*

I understand that ***signing this Authorization is voluntary and is not a condition of my treatment*** *(45 C.F.R. § 164.508(c)(2)(ii); 45 C.F.R. § 164.508(b)(4)).*

I understand that, for copies of medical records provided ***directly to me****, Twickenham Pediatrics may charge a* ***reasonable, cost-based fee*** *as permitted by HIPAA, and our current fee is* ***$10.00*** *(45 C.F.R. § 164.524(c)(4)). However, when records are* ***transferred directly to another treating physician as part of a transition of care****, they will be sent at no charge, consistent with HIPAA's permission to disclose PHI for treatment purposes (45 C.F.R. § 164.506(c)(2)).*

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