HIPPA Compliant Authorization for Release of Protected Health Information To the Office of Northwest Hills Pediatrics Pursuant to 45 CFR 64.508

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ - _____ - _____

I Authorize:

Name of Healthcare Provider/Physician/Representative:

_____

Representative Capacity

_____

Street Address

_____

City, State, Zip Code

_____

Office Phone Number Fax Number:

I authorize and request the disclosure of all protected informaion for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

Specific Information To Release:

☐ All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient, emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, photographs, videotapes, telephone messages, and records received by other medical providers.

☐ All physical, occupational and rehab requests, consultations and progress notes.

☐ All laboratory, histology, pathology, immunohistochemistry records and specimens; radiology records including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.

☐ All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period _____to _____.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

For the purpose of:

☐ Transfer ☐ Insurance ☐ Continuation of Care

☐ Legal ☐ Personal Reasons

☐ Other: _____

This authorization is given in compliance with federal consent requirements for release of alcohol or substance abuse records 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release my protected health information to:

Northwest Hills Pediatrics
538 Litchfield St, Suite G02
Torrington, CT 06790
(P) 860-489-5068 (F)860-489-3725

I understand that the following:

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy, or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from the date of execution at which time this authorization expires.

_____

Signature of Patient or Legally Authorized Representative Date

_____

Name and Relationship of Legally Authorized Representative to Patient

_____

Witness Signature Date