ADA PEDIATRICS, P.A.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

650 N. COLE RD BOISE, ID 83704
(208) 323-1222 f (208) 323-1825

ADA Pediatrics, P.A. will not receive payment or other remuneration from a 3rd party in exchange for using or disclosing the PHI. I do not have to sign this authorization in order to receive treatment from Ada Pediatrics, P.A. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the *Information Privacy Officer* at 650 N. Cole Road Boise, Idaho 83704.

I, _________________________________, hereby authorize the transfer of medical records of,
_________________________, DOB ___/___/___,

From:
Provider Name/Facility____
Address ____ City/State/Zip ___________________
Phone __________________________ Fax ________________________

To:
Provider Name/Facility____
Address ____ City/State/Zip ___________________
Phone __________________________ Fax _________________________

1. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable categories)
__ Transfer of care __Continued Care __ Personal Use __ Insurance Eligibility/Benefits __ Disability Determination __ Legal Investigation __ Other (specify): _____________________

2. HEALTH INFORMATION TO BE RELEASED:
__ All Records __History and Physical __Discharge Summary __ Lab __X-ray and imaging reports __EKG __Operative Report __ Pathology Report __ Other: _____________________

Federal and state laws require special permission to release certain information.
Please check if these records should be released:
__ Mental Health __ Alcohol and/or Drug Abuse __ HIV/AIDS Test Results __ Developmental Disabilities

3. EXPIRATION
This authorization will expire on _______/_______/_______ (DD/MM/YYYY). If I do not indicate a date, this will expire one (1) year from the date of my signature below. A photocopy of this authorization is as valid as the original.

4. SIGNATURE OF PARENT OR GUARDIAN
I understand that this authorization is voluntary. I am confirming my authorization that the health care provider may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature: ____ Date: _____/_____/_____

Relationship to Patient: ____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.