AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (INCOMING RECORDS)

PATIENT INFORMATION (Please Print)

Patient Name: _____

Social Security Number: _____

Patient Date of Birth: _____

Patient Home Phone Number: _____

Patient Address: _____ City _____State ___ Zip Code_____

I, _____, authorize **the following provider of care** to disclose and provide photocopies of the health-care information indicated below to **Goodlettsville Pediatrics, P.C.** and it's providers **at:**
200 Gleaves Street, Suite A, Madison, TN 37115 by US Mail **(please do not staple records)**
or **via facsimile to (888)-599-5833 (preferred electronic method).**

_____
Name of person(s) or company to release information

(_____) _____ (_____) _____
Phone Number Fax Number

_____ _____, _____ _____
Street Address City State Zip Code

Information To Be Released – Covering the Periods of Health Care
From (date)_____ to (date)_____

Please check type of information to be released:
| | Registration Sheet | | History and Physical Exams | | Phone Messages | | Lab Results | | Consultation Reports | | Progress Notes (Office Visits)
| | Other (specify) _____
| | Radiology Reports (X-Ray, MRI, Ultrasound, etc) _____ | | Photographs, or other images
| | Billing Records | | Payment Records
| |Entire Medical Record

Purpose of Request/Disclosure
| | Treatment or Consultation
| | Personal Copy
| | Legal
| | Military
| | Insurance Application
| | Continuing Care
| | Changing Physicians
| | Other, (specify)_____

Revocation – I understand that I may revoke this authorization at any time by sending a written request to GoodPeds. However, the revocation will not have any effect on any uses or disclosures GoodPeds may have made before the revocation was received.

Expiration – I understand that unless I revoke the authorization earlier, this authorization will automatically expire six (6) calendar months or 180 calendar days after the date this authorization is signed.

Re-Disclosure - I understand the information disclosed by this authorization may be subjected to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act 1996. This facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Certification – I certify that I am (check whichever applies):
| | the patient, and the identification that I have provided is true and correct.
| | the patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct.
My relationship to the patient is that of : _____.

Signature of Patient or Personal Representative Who May Request Disclosure

_____ _____
Signature of Patient Date Signed

_____ _____
Signature of Authority to Sign if not patient Date Signed

Identity of Requestor Verified via: | |Photo ID Matching Signature | |Other, specify_____

For Office Use Only:
Date Received: _____ Expiration Date: _____

How was identity verified? _____ Copy Scanned to Chart | | Yes | | No

How was authority verified? _____ Copy Scanned to Chart | | Yes | | No

By: _____ Title: _____ Date: _____

Date Scanned to EMR: _____ By: _____