Birmingham Pediatric Associates
Records Authorization
Patients 14 years of age or older must sign this form

_____ _____
Patient name Date of birth

I, _____ hereby authorize _____(the "Practice"), its employees and/or agents to use and/or disclose/send protected health information (PHI"):

☐ **FROM:** Practice address
_____
_____

TO: Birmingham Pediatric Associates
806 St. Vincent's Dr., Suite 615
Birmingham, AL 35205

☐ **FROM:** Birmingham Pediatric Associates
806 St. Vincent's Dr., Suite 615
Birmingham, AL 35205

TO: Practice address
_____
_____

Email:_____

Fax: _____

☐ **PICK-UP: who will be picking up the information:_____**

I understand that PHI used and/or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

1. Specific type of PHI to be used and/or disclosed (including dates):
   - o Entire Record
   - o Medication List
   - o List of Allergies
   - o Immunization Records
   - o Most Recent History and Physical
   - o Most Recent Discharge Summary
   - o Laboratory Results From(date)_____ to (date)_____
   - o X-ray and Imaging Reports From(date)_____ to (date)_____
   - o Consultation Reports From (Doctors' names) _____
   - o Patient Account/Billing Records From(date)_____ to (date)_____
   - o Other: _____

2. The following is the purpose(s) of the use and/or disclosure of my PHI shown above
   - o Changing Physicians
   - o Moving out of the area
   - o Referred to a specialist
   - o To have a personal copy of the records
   - o Other: _____

3. I understand that this Authorization is voluntary, and I have the right to refuse to sign this Authorization. The Practice may not refuse to provide health care treatment to me if I do not sign the Authorization.

4. I understand that upon my request I may see and copy the protected health information described on the Authorization. *I understand that my PHI may include information concerning sexually transmitted diseases, behavioral and mental health services, and treatment for drug and alcohol abuse.* I understand then I may be charged a reasonable, cost-based fee for uses and disclosures made upon my request.
5. I understand the I may revoke this Authorization in writing, at any time by sending my written revocation to the Privacy Officer at 806 St. Vincent's Drive, Suite 615, Birmingham, AL 35205. I understand that any revocation will not affect any actions taken by the Practice prior to receipt of my revocation.
6. I understand that this Authorization will expire one year from the signature date if an expiration is not provided (such as a date, event, or condition).

   I elect to have this Authorization expire on_____

7. I agree to release the Practice, its employees, agents, officers, and directors, from any and all liabilities and responsibilities for use and disclosure of the above information to the extent indicated and authorized pursuant to the signed Authorization.

Patients 14 years of age or older must sign this from

Name of patient or Personal Representative (This Authorization MUST be completed before signing)

_____ _____

Signature Print Name

_____ _____

Date Relationship to patient (if not the patient)

Best Contact number to reach you for questions about this request_____

If mailing authorization back to Birmingham Pediatric Associates, mail to the following address:

Birmingham Pediatric Associates
806 St. Vincent's Drive
Suite, 615
Birmingham, AL 35205
Fax: 205-939-4614

Or email to Records@birminghampeds.com