AUTHORIZATION FOR BIRMINGHAM PEDIATRIC ASSOCIATES, INC TO RECEIVE PROTECTED HEALTH INFORMATION

Patients 14 years of age or older must sign this form

I, _____ hereby authorize Birmingham Pediatric Associates, Inc. (the "Practice"), its employees and/or agents to RECEIVE **protected health information** ("PHI") from:

Whom: _____
(To whom is the information to be disclosed)

How **MAIL**

- *If by **MAIL**, mail to **806 St Vincent's Drive, Suite 615, Birmingham AL 35205***

FAX

- *If by **FAX,** our fax# is **205 939 4614***

Regarding: (name of patient) _____(patient's date of birth) _____

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 protected health information to be used and/or disclosed (including dates(s):

❑	ENTIRE RECORD >>>> >>>> **includes all of the categories listed below (except billing)**	
❑	Medication list	
❑	List of allergies	
❑	Immunization records	
❑	Most recent history and physical	
❑	Most recent discharge summary	
❑	Laboratory results	From (date) _____ to (date) _____
❑	X-ray and imaging reports	From (date) _____ to (date) _____
❑	Consultation reports	From (doctors' names) _____ _____
❑	Patient Account/Billing Records	From (date) _____ to (date) _____

Other

- ❑ _____
- ❑ _____
- ❑ _____

2. **The following is the purpose(s) of the use and/or disclosure of my protected health information**
   - ❑ **Changing physicians**
   - ❑ **Moving out of the area**

*** PLEASE TURN FORM OVER TO COMPLETE AND SIGN ***

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 this Authorization.

4. I understand that upon my request I may see and copy the protected health information described on this Authorization. *I understand that my protected health information may include information concerning sexually transmitted diseases, behavioral and mental health services, and treatment for drug and alcohol abuse*. I understand that I may be charged a reasonable, cost-based fee for uses and disclosures made upon my request

5. I understand that 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 this signed Authorization.

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Name of Patient or Personal Representative ***(This Authorization MUST be completed before signing.)***

_____ _____

Signature **Printed Name**

Date: _____

If by patient's representative, describe relationship to the patient and authority to act on behalf of patient:_____.

****TELEPHONE NUMBER WHICH WE MAY USE TO CONTACT YOU : _____ ****

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
205 933 2750
1 800 599 6554