LAKE AREA PEDIATRICS

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HIPPA Authorization for Release of Information Form

I authorize _____Healthcare Provider

_____Address

_____Phone & Fax number

To use and disclose the protected health information as described below to:

_____Healthcare Provider or
Individual seeking records
_____Address

_____Phone & Fax number

RECORDS ON (PATIENT NAME): _____ DOB _____

Specific description of information to be released:

_____ALL RECORDS INCLUDING VACCINATION RECORDS

_____SPECIFIC DATES OF SERVICE ONLY (list dates)_____

This protected health information is being used or disclosed for the following purposes:

_____

This authorization will expire on _____, or one year after the date of this authorization. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

Finally, you may revoke this authorization in writing at any time by sending written notification. Your notice will not apply to actions taken by the requesting person/entity prior to the date we receive your written request to revoke authorization.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

_____ _____ _____
Signature of Individual or Guardian Date Date of Birth

_____ _____
Printed Name Guardian's relationship to minor

A COPY OF THIS RELEASE OF INFORMATION MUST BE GIVEN TO THE INDIVIDUAL