4000 Pine Lane
Bessemer, AL 35022
Ph: 205-271-0899
Fax: 205-263-9509

200 Riverhills Business Park
Suite 250
Birmingham, AL 35242
Ph: 205-995-0899
Fax: 205-995-0451

Authorization to Disclose Health Information

Patient Name: ____ Date of Birth: ________________________________

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I authorize Growing Up Pediatrics, P.C to use or disclose the above named individual's health information as described below:

_______ Immunization record _______ Entire record _______Other ____________________________

_______ I would like a copy of my child's records and I agree to pay for the copies

_______ Release my child's records to the physician or facility named below for further treatment

_______ My child is a new patient of Growing Up Pediatrics, P.C. Obtain my child's records from the physician named below

_______ I am leaving Growing Up Pediatrics, P.C. Transfer my child's records to the physician named below

Obtain my child's records from:

Name: ____

Address: ____

____

Phone: ____ Fax: ____

Release my child's records to:

Name: ____

Address: ____

____

Phone: ____ Fax: ____

I understand that the information in the health record(s) listed above may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Privacy Officer at 200 Riverhills Business Park, Ste 250, Birmingham, AL 35242. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ______________________________________. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524 of the Federal Register Rules and Regulations. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure or my health information, I can contact the Privacy Officer, Jeff Bonner, at 995-0899.

I understand that I am financially responsible for the following fees associated with my request: copying charges, including the costs of supplies and labor, and postage related to the production of my information. I understand that the charge for this service is $.25 per page and that Growing Up Pediatrics, P.C has 30 days to comply with my request. GUP may, at its sole discretion, decide to waive these fees if the records are sent to another physician, or for any other reason.

____ _______________________________________

Signature of Patient or Legal Representative Date

____ _______________________________________

If signed by Legal Representative, Relationship to Patient Signature of Witness