Important – Please read: Copy fee for Patient Requests: {Rule 71 of the Federal Register}
Pages 1-10: $1.00 per page, Pages 11-50: $0.50 per page, Pages 51 & up: $0.25 per page
$10.00 Expedite Fee (IN Code 16-39-9-3), Postage (cost to mail)
The following not imposed to patients: $20.00 Retrieval Fee (inc. pgs. 1-10) $20.00 Certify Fee

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Jeffersonville Pediatrics to use and/or disclose

certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits Jeffersonville Pediatrics to use or disclose to_____
(Include accurate and complete name and address of individual or entity receiving records. Incomplete information will not be processed.)

_____

the following individually identifiable health information:
(mark only one box)

- ❑ Entire medical record (**INCLUDING** Communicable Diseases and Drug and Alcohol treatment records)
- ❑ Entire medical record (**EXCLUDING** Communicable Diseases and Drug and Alcohol treatment records)
- ❑ Specific information:

Such as date(s) of service, level of detail to be released, origin of information, etc.:

_____

Purpose of release:

- ❑ Leaving our Office for New Pediatrician/Physician
- ❑ Seeking Copy for Personal Reasons
- ❑ Other _____

This authorization will expire on _____.
(Include an Expiration Date or Defined Event. Valid for no more than 60 sixty days of receipt.)

When my information is used or disclosed pursuant to this authorization, it may be subject to

redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except to the extent that

Jeffersonville Pediatrics has acted in reliance upon this authorization. My written revocation

must be submitted to Jeffersonville Pediatrics, Privacy Officer at 207 Sparks Ave., Ste. 403,

Jeffersonville, In 47130.

Signed by: _____ _____ _____
Signature of Patient or Legal Guardian | Date | Relationship to Patient

_____ _____
Patient's Name | Date of Birth

_____ _____
Print Name of Patient or Legal Guardian

_____
(complete patient address)