Huntsville Pediatric Associates
Request for Medical Records
Phone 256.888.5437 Fax 256.705.1156

(This form applies only to the release and disclosure of information. It is not a consent for treatment or intended for any other purposes.)

Patient Name: _____ DOB: _____

By signing this form, I _____ authorize this facility

(Provide name) _____

to release, or disclose the protected health information described below to:

Name of Person and/or Organization to Whom Information Should be Sent: **(Please Circle Authorized Physician)**				
Rebecca Cochran, M.D.	Kevin S. Ellis, M.D.	Katie D. Gunter, M.D.	Angela King, M.D.	Michael Klemm, M.D.
Bryan Laue, M.D.	Brian Patz, M.D.	Christen Roth, M.D.	Sarah Todd, M.D.	

Address of Person/Organization to Whom Information Should be Sent:
Huntsville Pediatric Associates, LLC
2004 Airport Road, Suite 1
Huntsville, Alabama 35801

This authorization expires upon the fulfillment of request.

Purpose of Disclosure:

_____ Leaving Practice	_____ Relocating/Transfer

I authorize the following information to be sent to the address above:

Copies of all Medical Records from:	____ / ____ / ____ Mo Day Year	____ / ____ / ____ Mo Day Year
Copies of the information described below from:	____ / ____ / ____ Mo Day Year	____ / ____ / ____ Mo Day Year
_____ History and Physical	_____ Labs, X-Ray, etc.	_____ Office notes, Correspondence
_____ Other (Please specify in provided area)*	*	

I understand that there may be information in these records that I would not want released. _____ (Initial)

I have been provided a copy of this facility's *Notice of Privacy Practices* and any charges that may be associated with this authorization. I have discussed any concerns I may have about the use, release, and disclosure of my health information with this facility's Privacy Officer or other appropriate office personnel.

I understand that the recipient listed above may redisclose this released medical information. I do not hold this facility responsible for the use or misuse by others of my health information disclosed under this authorization. I release this facility from any legal liability that may arise from this authorization.

Patient Signature: _____ ***Date:*** _____

SSN: _____ ***DOB:*** _____

Relationship to Patient: _____ ***Parent Phone #*** _____

****If a patient is fourteen years or older he/she must sign for the release of their medical records. There are no exceptions unless the child is physically or mentally handicapped.***