Huntsville Pediatric Associates
Request for Medical Records

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

By signing this form, I _____ authorize this facility (Provide name) _____ to release, or disclose the protected health information described below to:

Patient's Name: _____

Name of Person and/or Organization to Whom Information Should be Sent:
(Please Circle Authorized Physician)

Rebecca Cochran, M.D.	Michael Klemm, M.D.
Bryan Laue, M.D.	Brian Patz, M.D.
Timothy Stewart, M.D.	Kevin S. Ellis, M.D.
Katie Gunter, M.D.	Sarah Pettigrew, M.D.

Address of Person/Organization to Whom Information Should be Sent:
Huntsville Pediatric Associates, LLC
1963 Memorial Parkway, Suite 5
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:
_____
*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.
*After completion of this release, please forward to your previous physician.