Huntsville Pediatric Associates
Request for Medical Records

(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.	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
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, Coorespondence
_____ 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.***

***After completion of this release, please forward to your previous physician.**