

HIPAA AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

I hereby authorize: **WILLOWS PEDIATRIC GROUP, P.C.** to release the complete medical/mental health records in their possession including, but not limited to; all records for care and treatment, nurses notes, emergency room records, records from previous Providers, Consultant notes, X-ray reports, Laboratory and all data referring to treatment of alcohol use, and/or drug use, and/or psychiatric treatments and/or sexual issues, and/or HIV status/testing/treatment:

If any of the information to be released constitutes a psychiatric communication or a communication with a psychologist, this release will serve as my written release of that information. I understand that I may refuse to grant the consent for this release of psychiatric/psychological information, and such a refusal will in no way jeopardize my right to continue to obtain treatment, unless disclosure is otherwise permitted by law or necessary for treatment. I understand that no psychotherapy notes may be disclosed by my signing this authorization, and that a separate authorization would be required for the release of psychotherapy notes.

If any of the information to be released relates to treatment for alcohol and drug abuse, I understand that there are special requirements for my consent to release as found in Part 2 of Title 42 of the C.F.R. which prohibits the further release of that information without my consent, as referenced in the federal regulations, or as otherwise permitted by law.

The information to be used/disclosed consists of: (description must be specific and meaningful)

---

---

The information will be used/disclosed for the following purposes:

---

---

Please circle reason for transfer: Relocation / To "Adult Physician" / Change of Insurance (which? \_\_\_\_\_)  
Other (please explain): \_\_\_\_\_

---

RELEASE/SEND TO:

---

---

---

---

FAMILY NAME: \_\_\_\_\_

Child(s) Name(s):	(Date of Birth)	(Signature*)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

This authorization is valid unless and until it is revoked, in writing, and properly presented to the records office of the provider listed above.

I understand that if the person or the entity that receives the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by submitting a written notice of my revocation, except to the extent that action has been taken in reliance on this authorization.

The authorization expires \_\_\_\_\_

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_  
(Parent/responsible person/authorized representative)

**(\*Please note that a child 13yrs old or older must sign permission for records release)**

Date: \_\_\_\_\_

If a representative signs, describe the representative's authority to act on behalf of the patient:



PLEASE NOTE: We must ask you to show ID if you are picking up your records. If someone other than the parent/responsible party picks up records they will be required to present written permission to do so from the parent/responsible party.