# Infants' and Children's Clinic, P.C.

Authorization to Disclose Protected Health Information

Patient Name:_____ Date of Birth:_____

**The following person or entity is authorized to disclose my medical records:**

**Infants' and Children's Clinic, P.C.**
Address: **421 W. College Street**
**Florence, AL 35630**

Phone: **256-764-9522**
Fax: **256-764-1139**

**The disclosure will be made to the following person or entity:**

Dr: _____

Address: _____

Phone #/Fax # _____

**For the purpose of:**

- ❑ At the request of the patient/parent/legal guardian
- ❑ Consultation with non-healthcare provider/school nurse about child
  Person or entity _____

OR: _____

**The type and amount of information to be used or disclosed:**

- ❑ Problem list, Immunization Record, Medication list, Most Recent History and Physical
- ❑ List of Allergies
- ❑ Conner Scales
- ❑ Most Recent Discharge Summary
- ❑ Psychotherapy Records From(date) _____ to(date)_____
- ❑ Laboratory Results From(date) _____ to(date)_____
- ❑ X-Ray and Imaging Reports From(date) _____ to(date)_____
- ❑ Consultation Reports From(Doctor's Name(s)) _____

Other _____

**I hereby authorize the use or disclosure of information about the above named individual and I understand that:**

1. This information about me is protected under federal law.
2. I may refuse to sign the authorization.
3. I have the right to revoke this authorization in writing.
4. Any revocation will be effective only to the extent that action has not been taken in reliance of my prior authorization.
5. Unless I revoke this authorization, it will expire on the following date ____/____/____, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.
6. By signing below, I recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law.
7. Treatment or payment will not be based on my signing this authorization.
8. I will receive a copy of this authorization.

_____ _____
Signature of Patient/Parent/Legal Guardian Date

_____ _____
Relationship to the Patient Signature of Witness

**Revised: June 16, 2014**