Northpoint Pediatrics Authorization for Release of Protected Health Information
OUTGOING RELEASE OF RECORDS

1. Patient Information:

Patient's Name: ____ Patient's Date of Birth: _________________________

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Patient's Address:____ Patient's Telephone Number:___________________

Name of Primary Care Doctor: ____

I hereby authorize and consent to disclosure of health records as stated below. I am aware that the records disclosed might contain records whose confidentiality is protected by either the Federal Drug & Alcohol Confidentiality Law (42 C.F.R. Part 2) or the State Mental Health Records Law (I.C. 16-39-2). I understand the records released may include alcohol and/or substance abuse, mental health and communicable disease documentation (including HIV results) unless I specifically prohibit the release of this information.

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2. I authorize Northpoint Pediatrics to release records to: ***please choose one – thank you!***

Name of Doctor/Person/Organization to whom the disclosure is to be made: ______________________________

_____ Fax # for records to be sent to: ____

_____Address for records to be mailed to: ____

_____Pick up in office (we will call you when records are ready) At which location would you like to pick the records up? _____Castleton _____Fishers (Parkside Dr) _____Saxony (Olio Rd)

_____**Email to parent's email address**: ____

Please provide a home email address – not work email address

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3. The purpose or reason for this disclosure is:

_____Leaving practice due to _________________**If you are moving out of the area please notate moving date: _____________

**If moving, please list new address and phone #____

_____Not leaving the practice – Need records for ____

____Release of health form to third party – fee associated is for completion of form.

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4. We are happy to release the following records free of charge, please check which you would like:

_____Immunizations _____Growth Curve _____Last well child exam

There is NO fee to copy the first 10 pages, postage fee only if mailed. $.25 per page (pgs copied after first 10 pgs) plus postage.

Other records:____

This request may be revoked by the patient at any time by communicating in writing that intent to the provider.
I understand that the information used or disclosed may be subject to redisclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy 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.
This authorization expires 1 year from the date of signing.

IF PATIENT IS 18 YEARS OR OLDER, PATIENT IS HIS/HER OWN LEGAL GUARDIAN AND MUST SIGN THIS FORM TO RELEASE MEDICAL RECORDS INFORMATION.

______________________________	______________________________	____________________
Parent/Legal Guardian/18yr & over Patients	Printed Name	Date Signed

Office use only: Release processed and JMJ encounter note entered by:__________________________ Date Completed: _______________________________
Release scanned into JMJ by: ____Date Scanned:____

Date of last revision 1/3/2012