

NORTHPOINT PEDIATRICS
Authorization for Release of Protected Health Information
INCOMING RECORDS

Name of Primary Care Doctor: _____

1)

Patient Name

Patient's Date of Birth

Patient's Address

City, State, Zip Code

Patient's Telephone

I hereby authorize and consent to disclosure of health records as stated below. I am aware that the records disclosed might be records whose confidentiality is protected by Federal Regulations (45 C.F.R., Part 2) or State Regulations (I.C. 16-39-16). The records may include alcohol and/or substance

2) **I Authorize Northpoint Pediatrics to receive information from:**

Name of Person or Organization releasing information

Phone Number

Street Address

City, State, Zip Code

Northpoint physicians request the last physical, immunization and growth curve. If your child has had a chronic illness or serious medical condition the Northpoint physicians request all previous medical records.

3) Information to be disclosed:(choose all that apply) / List date range: _____

Last Physical

Growth Curve

Immunizations

Other: _____

I authorize the release of information protected by Federal and State Regulations including alcohol/substance abuse, mental health documentation, and HIV results.

4) This request is good for 60 days from the date signed pursuant to I.C. 16-39-1-1 unless I have indicated

5) This request may be revoked by the patient at any time by communicating that intent in writing to the provider. _____

6) **Information is to be mailed to:**

Northpoint Pediatrics
8101 Clearvista Parkway #185
Indianapolis, IN 46256

7) 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.

8) I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to receive medical treatment.

Signature of Legal Parent or Legal Guardian

Date Signed

Printed Signature