AUTHORIZATION FOR RELEASE OF INFORMATION

Southpointe Pediatrics 8851 Southpointe Drive C-1 Indianapolis, IN 46227 317-887-3344 Fax 317-885-5018

Patient Name: _____**THERE IS A FEE FOR THIS SERVICE**

Approximate fee - up to $20.00 per chart

You will be billed for this service.

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Telephone: _____

I hereby authorize and consent to disclose of health records as stated below. Unless limited below, I understand that this release also pertains to records whose confidentiality is protected by either Federal Regulations (42 CFR Part 2) or State Law (IC 16-39-2) concerning hospitalization or treatment, including but not limited to, alcohol abuse, substance abuse, communicable disease documentation, human immunodeficiency virus (HIV) or mental health treatment or counseling.

1. Information to be disclosed (dates of service): _____

- ❒ Office Visit/Progress Notes
- ❑ Laboratory Reports
- ❒ Radiology Reports (x-ray, CT, MRI, etc.)
- ❒ FMLA paperwork
- ❒ Work/School Note
- ❒ Immunization record only
- ❒ Complete Daycare/Sport Form
- ❒ **All Records in Chart - may include billing** and or insurance information

Other: _____

2. I authorize: **Southpointe Pediatrics** to release information to: _____

** We need complete address or fax# _____

_____

3. **The purpose or need for this disclosure (required by law.)** Insurance plan change Billing Issues

Age NOt satisfied with physician Not satisfied with office staff Not satisfied with service

Moving or location closer to home Dismissed from practice

Other:_____

4. This consent is valid for as long as reasonable necessary to fulfill the purpose for which it is given. This will not exceed 60 days.
5. This consent may be revoked at any time, except to the extent that action has already been taken. To revoke this authorization, I will notify the Privacy Contact in writing.
6. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
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. There will be a charge plus postage fee for copy of medical records. This fee is not billable to your insurance company. There are fees associated with the completion of daycare, school, sports, camp, etc. forms. A fee also applies to the completion of FMLA paperwork. Fees for forms must be paid in advance of forms being completed. Form fees are not billable to your insurance company.

9. Information to be released:

- ❒ Verbally
- ❒ Photocopy
- ❒ Faxed (we will only fax: immunization records, forms or minimal page requests. All others will go via photocopy by mail)

_____

Signature of Parent/Guardian/Patient if at least 18 yrs of age **Date**

This signature also pertains to records whose confidentiality is protected by Federal Regulations (42 CFR Part 2) or State Law (IC 6-39-2).