

VIP MIDSOUTH, LLC

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Patient Authorization for Practice to Release Protected Health Information to Third Parties

I hereby authorize the use or disclosure of my health information as described below. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected by federal privacy regulations.

Patient Name: _____ Date of Birth: _____

Practice/Physician to Receive Information: Practice/Physician to Release Information:

Purpose of the use or disclosure:

At the request of the individual _____ Changing Physicians _____
Moving _____ Physician/Staff Request _____ Other _____

I have the right to revoke this authorization in writing except to the extent that the provider has acted in reliance upon this authorization. My written revocation must be submitted to the designated Privacy Officer.

____ Please release my child's shot record, growth chart, and diagnosis history at no charge.

____ Please release my child's entire record for a fee of \$20 for the first 5 pages and \$0.50 each sheet starting at page 6. I understand an additional fee may be applied for postage and affidavit.

____ I would like my records in electronic format

____ I will pick up requested medical records once notified by office.

____ I request that medical records be mailed to me at: _____

*Medical Record Disclosure:

Our office may take up to 10 business days to process this request.

This authorization will expire 30 days from the date signed and only covers treatment prior to that date.

Signed: _____
(Signature of Parent/Guardian/Patient)

Relationship: _____

Witness: _____

Date Signed: _____

Office Use Only:

Date Processed: _____ By: _____

Records: Picked Up/Mailed (please circle one)

Fee Paid: _____

Method of Payment: _____