Alice Pediatric Clinic
Children's Healthcare

Patient Request for Access to Protected Health Information

Contact Information

Name of Patient _____ Date of Birth _____

Address (City, State, ZIP) _____ Phone _____

_____

Dates of Service _____ Date Information Needed _____

Mail copies to __ Address listed above Phone _____

__ Address listed below

Address (City, State, ZIP) _____

_____

Authorization

I authorize Alice Pediatric Clinic to disclose the protected health information about myself (or the patient) as described above. I understand:

- This authorization expires 180 days from the date of my signature unless I specify otherwise.
  Expiration _____
- I may revoke this authorization at any time by notifying Alice Pediatric Clinic in writing. If I revoke the authorization, I understand that it will have no affect on actions Alice Pediatric Clinic took in good faith before receiving the revocation.
- The information released may contain information related to AIDS or HIV infection; drug or alcohol abuse; mental or behavioral health or psychiatric care, except for psychotherapy notes.
- If the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
- Alice Pediatric Clinic may not condition treatment or payment on my completion of this form.
- Alice Pediatric Clinic reserves the right to verify my identity or guardianship.
- I will be charged for the copies requested.

  Signature _____ Date _____

  Printed Name _____

  Relationship to Patient _____

Reports Requested

Document Type	Fee	Requested	Document Type	Fee	Requested
Patient transfer summary (summary of chart for release to another physician)	$25.00		Affidavit	$15.00	
Immunization Record	$ 5.00		CPS Record	$25.00	
Lab Report	$ 5.00		Worker's Compensation Request	$25.00	
Growth Chart	$ 5.00		Retrieval Fee (to obtain records from storage)	$25.00	
Entire Paper Record	$25.00		Electronic Record via CD	$25.00	
Other					

Reason for Transfer

Please indicate the reason why you are transferring out of our practice.

Moving out of the city or state _____
Child is transitioning to an adult physician _____
Practice does not accept insurance _____
Dissatisfied with care _____

Thank you for choosing Alice Pediatric Clinic

September 2013