

# NORTHERN LIGHTS PEDIATRIC & ADOLESCENT MEDICINE

## Release of Information

<b>Patient Information</b>	<b>Name:</b> _____ <b>Date of Birth:</b> _____ <b>Address:</b> _____ <b>Phone Number:</b> _____ <b>City:</b> _____ <b>State:</b> _____ <b>Zip:</b> _____
<b>Clinic/Hospital/Health Care Provider</b>  (Who has the information you want released?) Please list the specific clinic and/or hospital.	<b>Name:</b> _____ <b>Address:</b> _____ <b>Phone:</b> _____ <b>City:</b> _____ <b>State:</b> _____ <b>Zip:</b> _____ <b>Fax Number:</b> _____
<b>Receiving Party</b>  (Where do you want the information sent?)	<b>Name:</b> _____ <b>Address:</b> _____ <b>Phone:</b> _____ <b>City:</b> _____ <b>State:</b> _____ <b>Zip:</b> _____ <b>Fax Number:</b> _____
<b>Information to be Released</b>  (What do you want sent or released? Check the appropriate box.)	<input type="checkbox"/> Specific dates/years of treatment _____ <input type="checkbox"/> ALL health records Or ONLY records types checked below <input type="checkbox"/> History/Physical <input type="checkbox"/> Progress notes <input type="checkbox"/> Consultations <input type="checkbox"/> Lab report <input type="checkbox"/> Care Plan <input type="checkbox"/> Other information or instructions _____ <input type="checkbox"/> Medication <input type="checkbox"/> Immunizations _____ <input type="checkbox"/> Mental health <input type="checkbox"/> Radiology Repots _____
<b>Release Instructions</b>	Date information is needed: _____ (Please allow 7-10 days for processing)
<b>Purpose of Release</b>	<input type="checkbox"/> Continuation of Care by specialist <input type="checkbox"/> Insurance <input type="checkbox"/> Transfer of Care <input type="checkbox"/> Personal Use <input type="checkbox"/> Other _____

- This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: \_\_\_\_\_
- This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation.
- Northern Lights Pediatrics will not restrict my treatment if I choose not to sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- Only one free copy of records will be released (unless requested by a specialist, insurance company, or lawyer), if subsequent records are needed there may be a charge.
- Northern Lights Pediatrics records may include records that it received from other organizations. If these records have been used by Northern Lights Pediatrics authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Northern Lights Pediatrics from any and all liability resulting from a re-disclosure by the recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

Patient/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_