

NORTHERN LIGHTS PEDIATRIC & ADOLESCENT MEDICINE

Release of Information

Patient Information	Name: _____ DOB: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____										
I authorize the release of medical information from:	Clinic or Individual's Name: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____ Fax Number: _____										
Please release my protected health information (PHI) to:	Clinic or Individual's Name: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____ Fax Number: _____										
Information to be Released	<input type="checkbox"/> All Health Records for the past 2 years <input type="checkbox"/> Specific date(s) of treatment _____ OR ONLY record types checked below <input type="checkbox"/> Physicals <input type="checkbox"/> Progress Notes <input type="checkbox"/> Consultations <input type="checkbox"/> Lab Reports <input type="checkbox"/> Medications <input type="checkbox"/> Mental Health <input type="checkbox"/> Other - please specify _____										
Date Information Needed By: _____ (Please allow 7-10 days for processing)											
Purpose of Release (check all that apply):	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"><i>Transfer of care due to:</i></td> <td style="width: 50%; vertical-align: top;"><i>Non-Transfer request:</i></td> </tr> <tr> <td><input type="checkbox"/> New primary care clinic</td> <td><input type="checkbox"/> Consultation/Second Opinion</td> </tr> <tr> <td><input type="checkbox"/> 18+ or older/new primary care</td> <td><input type="checkbox"/> Coordination of Care</td> </tr> <tr> <td><input type="checkbox"/> Moving out of town/state</td> <td><input type="checkbox"/> Personal or School-related</td> </tr> <tr> <td><input type="checkbox"/> Insurance change</td> <td><input type="checkbox"/> Legal & Life Insurance application</td> </tr> </table>	<i>Transfer of care due to:</i>	<i>Non-Transfer request:</i>	<input type="checkbox"/> New primary care clinic	<input type="checkbox"/> Consultation/Second Opinion	<input type="checkbox"/> 18+ or older/new primary care	<input type="checkbox"/> Coordination of Care	<input type="checkbox"/> Moving out of town/state	<input type="checkbox"/> Personal or School-related	<input type="checkbox"/> Insurance change	<input type="checkbox"/> Legal & Life Insurance application
<i>Transfer of care due to:</i>	<i>Non-Transfer request:</i>										
<input type="checkbox"/> New primary care clinic	<input type="checkbox"/> Consultation/Second Opinion										
<input type="checkbox"/> 18+ or older/new primary care	<input type="checkbox"/> Coordination of Care										
<input type="checkbox"/> Moving out of town/state	<input type="checkbox"/> Personal or School-related										
<input type="checkbox"/> Insurance change	<input type="checkbox"/> Legal & Life Insurance application										

Authorization:

- This authorization expires one after my signature below.
- This authorization may be canceled in writing at any time. A cancellation will not change releases that happened 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 the original.
- Only one free copy of records will be released (unless requested by a specialist, insurance company, or lawyer), if subsequent records are needed a fee may be charged.
- Northern Lights Pediatrics may include records that have been 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 protection 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.

Signature of Patient, Parent, or Legan Guardian

Printed Name

Relationship to Patient

Date

(Patients 18 years or older are legally required to sign any/all authorizations)