South County Pediatric Associates, PC
Authorization for Release of Protected Health Information

_____ _____

Name of Individual/Other Name Used Birth Date

_____ _____

Street Address City, State, Zip, Phone

AUTHORIZES:

South County Pediatric Associates, PC
4850 Lemay Ferry Rd
Suite 120
Saint Louis, Missouri 63129
314-849-3320
Fax: 314-849-7766

RELEASE OF PROTECTED HEALTH INFORMATION TO:

_____

Individual/agency/organization making disclosure

_____

Street Address

_____

City, State, Zip Code, Phone

INFORMATION TO BE RELEASED:

The following is a specific description of the health information I authorize to be used and/or disclosed (please be specific regarding information you want released): _____

_____

In compliance with Missouri Statutes, which require special permission to release otherwise privileged information please release records pertaining to: [Check all that apply]

☐ Mental Health ☐ Alcohol &/or Drug Abuse ☐ HIV Test Results

☐ Other (Specify): _____

For the Following Date(s): From _____ to _____.

PURPOSE OF AUTHORIZATION: (Check applicable categories)

☐ Transfer Records ☐ Further Medical Care ☐ Coordinating Care for Child ☐ Insurance Eligibility/Benefits

☐Other (Specify): _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive Copy of This Authorization – I understand that if I sign this authorization, I may request a copy of this authorization.

Right to Withdraw This Authorization – I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to South County Pediatric Associates, PC. I am aware that my withdrawal will not be effective until received by South County Pediatric Associates, PC and will not be effective regarding the uses and/or disclosures of my health information that South County Pediatric Associates, PC has made prior to receipt of my withdrawal statement.

RE-DISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

EXPIRATION DATE: This authorization is good until (indicate date or event) _____. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PARENT/GUARDIAN: _____ DATE: _____

(Note: if signed by guardian, copy of legal guardianship papers required)