**Tots 'N' Teens Pediatrics, P.C.**
**3729 Mary Taylor Road**
**Birmingham, Al. 35235**

## AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

**Patient Name:**_____

**Date of Birth:**_____ **Phone#**_____

I understand that my protected health information (PHI) may include information concerning sexually transmitted diseases, behavioral and mental health services, HIV/Aids and treatment for drug and alcohol abuse.
I authorize the use or disclosure/transfer of the above named individual's protected health information as described below:

___ Entire Record
___ Immunization Records Only
___ Other_____

Purpose of Transfer: _____Change of Physician _____Other(Please state)_____

I wish to: _____Have records mailed _____Pick up records

Information listed above will be transferred from:

Name:_____

Address:_____

_____

Information listed above will be transferred to:

Name:_____

Address:_____

_____

- I understand that this Authorization is voluntary, and I have a right to refuse to sign this Authorization. Tots 'N' Teens Pediatrics, P.C. may not refuse to provide health care treatment to me if I do not sign.
- This authorization is effective for ninety (90) days unless revoked or terminated by the patient or the patient's personal representative.
- I may revoke or terminate this authorization by submitting a written revocation to Tots 'N' Teens Pediatrics, P.C. I should contact the Privacy/Compliance Officer to terminate this authorization.
- I understand that upon my request, I may see and copy the PHI described on this Authorization.
- Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may then not be protected under the federal privacy regulations.
- I agree to release Tots 'N' Teens Pediatrics, P.C., its employees, officers, and physicians from any and all liabilities and responsibilities for disclosure of the above information to the extent indicated and authorized pursuant to this signed Authorization.

**Signature**

_____

Signature of Patient – If Over 14 Years of Age Date

_____

Signature of Patient Representative Date

_____

Relationship of Patient Representative to Patient

**ATTENTION:**
THE FIRST COPY OF RECORDS IS COMPLIMENTARY. ADDITIONAL COPIES WILL BE SUBJECT TO COPY FEES AS STATED BY LAW.