QuickCare pediatrics

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HIPPA AUTHORIZATION RELESE OF PROTECTED MEDICAL RECORDS

Date: _____ (request will expire 90 days after this date)

Patient's Name: _____ DOB: _____ M/F

Address: _____ Phone: _____

I hereby authorize _____ to ***ONLY*** release the following medical records to QuickCare Pediatrics for continued care:

- ∅ Most Recent Annual Well Child Exam
- ∅ Immunization Records
- ∅ Medication List (current and previous)

Other: _____

I understand the information used or disclosed may be subject to re-disclosure by the person, persons, class, or facility receiving it and would no longer be protected by federal privacy regulations.
I may revoke this authorization by notifying the facility in writing of my desire to revoke it. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
I understand the provider to whom this authorization is furnished may not condition its treatment of me on whether I sign the authorization.
HIV-related information obtained in parts of the records indicated above will be released through this authorization unless otherwise indicated: ___ DO NOT RELEASE

Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____