MONTGOMERY
PRATTVILLE
CLANTON

CLANTON PEDIATRIC ASSOCIATES, P.A.
1011 LAY DAM ROAD
CLANTON, ALABAMA 35045

PHONE: (205) 280-4990 FAX: (205) 755-0226

AUTHORIZATION FOR RECEIPT OF MEDICAL RECORDS

Request Records From:

_____ ( )
Physician/Office Name Phone #

_____ ( )
Address Fax #

_____ _____
City State Zip Code

Information Requested:
(Check all that apply)

_____ Complete Medical Record

_____ Immunizations

_____ Labs or any test results

Purpose of Requested Information:
(Check all that apply)

_____ The request of patient

_____ Continued medical care

_____ Other: _____

Patient's Name (First,MI, Last): _____

Date of Birth: _____ Patient's medical insurance: _____

By signing this authorization, I authorize the use and disclosure of my Protected Health Information as requested. I understand that the information may be re-disclosed by the recipient and may no longer be protected by the federal HIPPA privacy rule. I do not have to sign the authorization in order to receive treatment from Clanton Pediatric Associates, P.A. I have the right to revoke this authorization in writing at any time except if Clanton Pediatric Associates, P.A. has acted in reliance upon this authorization. The explanation of this request will end 90 days from date signed by Parent/Guardian.

Medical records received from your previous doctor will be reviewed by a Clanton Pediatric Associate, P.A. provider. After your records have been reviewed and accepted by the reviewing provider, you will receive a phone call to establish the first visit. Medical records will be scanned into your chart and shredded for your privacy. If for any reason your child is not accepted we will hold the medical records for 120 days for pick-up by the signing parent/custodian. After that time they will be properly destroyed.

_____ _____ _____
Patient/Parent/Guardian (Please Print) Signature of Patient/Parent/Guardian Date

_____ ( )
Address Phone #

_____ _____ _____
City State Zip Code