PRATTVILLE PEDIATRIC ASSOCIATES, P.A.
645 MCQUEEN SMITH ROAD N., STE 301
PRATTVILLE, ALABAMA 36066

PHONE: (334) 361-7811 FAX: (334) 361-7804

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 Prattville Pediatric Associates, P.A. I have the right to revoke this authorization in writing at any time except if Prattville 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 Prattville 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