# VIP MIDSOUTH, LLC

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## Patient Authorization for Practice to Release Protected Health Information to Third Parties

I hereby authorize the use or disclosure of my health information as described below. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected by federal privacy regulations.

Patient Name:________________________ Date of Birth:____________________

Practice/Physician to Receive Information:

______________________________

______________________________

______________________________

Practice/Physician to Release Information:

______________________________

______________________________

______________________________

Purpose of the use or disclosure:
At the request of the individual________ Changing Physicians____________
Moving__________Physician/Staff Request___________ Other__________

I have the right to revoke this authorization in writing except to the extent that the provider has acted in reliance upon this authorization. My written revocation must be submitted to the designated Privacy Officer.

_____Please release my child's shot record, growth chart, and diagnosis history at no charge.

_____Please release my child's entire record for a fee of $20 for the first 5 pages and $0.50 each sheet starting at page 6. I understand an additional fee may be applied for postage and affidavit.

_____I would like my records in electronic format

_____I will pick up requested medical records once notified by office.

_____I request that medical records be mailed to me at: ______________________

______________________

*Medical Record Disclosure:
Our office may take up to 10 business days to process this request.
This authorization will expire 30 days from the date signed and only covers treatment prior to that date.

Signed:____________________________ Relationship:____________________
(Signature of Parent/Guardian/Patient)

Witness:____________________________ Date Signed:____________________

Office Use Only:
Date Processed: ____________ By:____________ Fee Paid:____________
Records: Picked Up/Mailed (please circle one) Method of Payment:____________