CLINE PEDIATRICS
We Love your kids too!

Cline Pediatrics

Marrietta D. Cline, M.D.

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient's name:	Date of birth:

I hereby request and authorize my child's medical records be transferred **TO:** Cline Pediatrics **FROM:**

Facility/Name of Doctor:	
Address:	
Phone:	Fax:

By initialing the spaces below, I specifically authorize the use or disclosure of the following health Information and/or records, if such information and/or records exist, for CONTINUITY OF CARE:

___Please send the entire medical record (ALL INFORMATION) to Cline Pediatrics ___Lab Reports ___Provider's Progress Notes ___Hospital Records ___Pathology Reports ___Most recent history ___Diagnostic Imaging Reports ___Medical History/Physical Exam ___Other

********The following items must be initialed to be included in the use and/or disclosure of other Health information:**

____HIV/AIDS related health information and/or records ____Medications prescribed ___Genetic testing information and/or records ____Drug/alcohol diagnosis, treatment and/or referral information (Federal regulations require a description of how much and what kind of information is to be addressed. Federal law prohibits the re-disclosure of such information).

____Psychiatric/Psychological evaluation report) ____Psychotherapy notes (if this authorization is for the use and/or disclosure of psychotherapy notes, then it cannot be combined with any other authorization).

***I understand that I may revoke this authorization at any time by giving written notice to the Practice Administrator. Unless revoked earlier, this authorization will expire one year from the date of signing. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information prescribed above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws or regulations. I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

_____ _____

Parent/Legal Guardian Signature | Date

_____ _____

Witness | Date

CONFIDENTIALITY NOTICE: CONFIDENTIAL HEALTH INFORMATION ENCLOSED!

Protected health information (PHI) is personal and sensitive information related to a person's health care. It is being faxed or mailed to you after appropriate authorization from the patient or under circumstances that do not require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.

IMPORTANT WARNING: The message is intended for the use of the person or entity to which is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If you are not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any disclosure, copying, or distribution of this information is strictly prohibited. If you have received this message by error, please notify the sender immediately to arrange for return of destruction of these documents.