Important – Please read: Copy fee for Patient Requests: {Rule 71 of the Federal Register}
Pages 1-10: $1.00 per page, Pages 11-50: $0.50 per page, Pages 51 & up: $0.25 per page
$10.00 Expedite Fee (IN Code 16-39-9-3), Postage (cost to mail)
The following not imposed to patients: $20.00 Retrieval Fee (inc. pgs. 1-10) $20.00 Certify
Fee for requests for an electronic copy of PHI maintained electronically: Flat Fee $6.50

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Southern Indiana Pediatrics to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits **Southern Indiana Pediatrics** to use or disclose _____
(Include accurate and complete name and address of individual or entity receiving records. Incomplete information will not be processed).

_____
the following individually identifiable health information:
(mark only one box)

- ❑ Entire medical record (**INCLUDING** Communicable Diseases and Drug and Alcohol treatment records)
- ❑ Entire medical record (**EXCLUDING** Communicable Diseases and Drug and Alcohol treatment records)
- ❑ Specific information:
- ❑ Electronic Copy of entire medical record (**INCLUDING** Communicable Diseases and Drug and Alcohol treatment records)
- ❑ Electronic Copy of entire medical record (**EXCLUDING** Communicable Diseases and Drug and Alcohol treatment records)

Such as date(s) of service, level of detail to be released, origin of information, etc.:

_____
_____

Purpose of release: _____ ❑ I am leaving the practice ❑ I am **NOT** leaving the practice

This authorization will expire in sixty (60) days unless otherwise specified: _____

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except to the extent that **Southern Indiana Pediatrics** has acted in reliance upon this authorization. My written revocation must be submitted to **Southern Indiana Pediatrics' Privacy Officer at 1701 Spring Street, Suite A Jeffersonville, IN 47130.**

Signed by: _____ _____ _____
Signature of Patient or Legal Guardian | Date | Relationship to Patient

_____ _____
Patient's Name | Date of Birth

_____ _____
Print Name of Parent or Legal Guardian | (patient complete Address)

_____
(Phone number of Parent or Guardian)