Children's of Alabama

Vestavia Pediatrics
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Birmingham, AL 35216
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Children's of Alabama –**Annual Form**
Authorization to Release Information (Past and Future Care)

Patient Name: _____ Date of Birth: _____
(First, MI, Last)

Address: _____ Contact Phone #: (___)_____

What information do you want to release? (by request only)	Where do you want this information to be sent? (examples may be school, work)
___ANY and All information OR *ONLY* ___Blue Forms/Immunization Records ____Work/School Excuses ____Medication Lists ___ Medical History/Physical Exam (example: sports) ____Physician Orders/Visit Notes ____Other:_____	Please print list of locations: MUST BE SPECIFIC Parent Fax_____ _____ School/Daycare_____ _____ _____ _____
HIV, Behavioral Health/Psychiatric, and Drug and Alcohol treatment information contained in the parts of the record(s) indicated above will ONLY be released when indicated by your initials below. Please initial if you authorize the [Practice Name] to release this information: ☐ ____ *HIV* ☐ _____ *Behavioral Health/Psychiatric* ☐ _____ *Drug & Alcohol*	

I authorize Vestavia Pediatrics and its employees/physicians to release the information stated above. I understand this authorization is voluntary and for my own convenience. I understand Vestavia Pediatrics will release only those items indicated by me unless there is a medical emergency. The health record(s) released by Vestavia Pediatrics may possibly be re-disclosed by the facility/person that receives the record(s) and therefore (1) Vestavia Pediatrics and its employees/physicians have no responsibility or liability as a result of the re-disclosure and (2) such information would no longer be protected by the HIPAA Privacy Rule. This Authorization is in effect for a period of **one year** from the date my signature unless a shorter time frame is documented. I have the right to revoke/change my mind about this Authorization form at any time by sending a written request to the Practice Manager at the Practice Address above. My decision to revoke the Authorization does not apply to any release of my child's health record(s) that may have taken place prior to the date of my request to revoke the Authorization.

_____ _____ _____
Patient/Parent/Guardian Print Name Patient/Parent/Guardian Signature date

_____ ____ _____ _____
Patient Signature if adult (ie: 19 or older) date Witness for Patient/Parent/Guardian date