MONTGOMERY PEDIATRIC ASSOCIATES, P.A.
420 COTTON GIN ROAD
MONTGOMERY, AL 36117
PHONE: (334) 260-9129 FAX: (334) 260-9665

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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: _____ SSN: _____

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 Montgomery Pediatric Association, P.A. I have the right to revoke this authorization in writing at any time except if Montgomery Pediatric Association, P.A. has acted in reliance upon this authorization.

_____ _____
Patient/Parent/Guardian (PLEASE PRINT) Signature of Patient/Parent/Guardian Date

_____ ( ) _____
Address Phone

_____
City State Zip Code