Intown
PEDIATRIC & ADOLESCENT MEDICINE, P.C.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME (*Last, First, MI*)			**Date of Birth**
Address	City	State	Zip
Best Contact Phone	Email Address		
PARENT/GUARDIAN NAME		Relationship to Patient	
My signature below affirms that I am the legal guardian of the above listed patient, having full authority to request, receive and transfer Medical Health Records. I agree to take full responsibility for such records and all financial obligations.			

I hereby Authorize Intown Pediatric & Adolescent Medicine, PC to:

☐ **Release my child's protected health information TO:**

_____ Name *(Physician or Practice)*

_____ Address

_____ City, State Zip Code

_____ Fax Number

_____ Phone Number

_____ Email

(Any documents over 30 pages will be emailed or mailed in CD format)

☐ **Check if RELEASING FROM another Practice/Physician to INTOWN PEDIATRIC & ADOLESCENT MEDICINE**

INCOMING MEDICAL RECORDS MAY BE EMAILED TO: **medicalrecords@intownpediatrics.com**

INFORMATION TO BE RELEASED:

☐ FULL Medical Record	☐ Records From & To Dates _____	☐ Last Visit/Growth Chart/Immunizations

RECORDS RELEASE REASON: ☐ SURGERY/SPECIALIST ☐ LEAVING AREA ☐ NEW PEDIATRICIAN/PRACTICE

This authorization expires 90 days (ninety) from: _____ **(Enter Expiration Date)**

☐ ***By checking this box, I authorize records to be sent via unencrypted email to my email address on file. I accept the risks of sending and receiving Protected Health Information (PHI) via unencrypted email and I hold harmless Intown Pediatrics from any and all liability.***

I understand that I may revoke this authorization at any time by notifying Intown Pediatric & Adolescent Medicine, in writing. This authorization will cease to be effective on the date notified except to the extent that the practice has acted in trust upon this authorization.

_____ **Signature of Parent or Legal Guardian**

_____ **Date**

Any medical record not submitted directly to another medical office is subject to a $30 per record fee. Any records over 30 pages cannot be faxed. Medical Records for Attorney offices are a minimum of $50 per patient record. Guarantor accepts full financial responsibility for all patient balances at the time of medical record request. Release of medical records to another primary care facility terminates patient care with Intown Pediatric & Adolescent Medicine.