Hillsborough Pediatric & Adolescent Medicine, PLLC

RECORDS REQUEST

Patient Name:_____

Date of Birth:_____

Patient Contact Phone Number:_____

I authorize Hillsborough Pediatric & Adolescent Medicine, PLLC to RELEASE or OBTAIN (please circle one) information to/from:

Name of Provider of Facility:_____

Address:_____

Phone Number:_____

Fax number:_____

Information to be released/obtained (check appropriate boxes):

☐Comprehensive report ☐Office visit notes ☐Laboratory reports ☐Immunization records

☐Radiology Reports ☐Operative reports/Procedure notes ☐Other:_____

I understand that my protected health information may be re-disclosed by the person/class of persons/facility receiving it, and would at that time no longer be protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by notifying Hillsborough Pediatrics in writing of my desire to revoke it. However, I understand that any action already taken on reliance of this authorization cannot be reversed and my revocation will not affect those actions. I understand that Hillsborough Pediatrics may not condition treatment of me upon whether or not I sign the authorization.

This authorization expires on_____or sooner if at any time I should revoke it, or upon the occurrence of the following expiration event for which this disclosure was authorized.

Printed Name of Legal Representative:_____Relationship to Patient:_____

Signature of Patient or Legal Representative:_____Date:_____

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