

**Release of Medical Information Authorization Form**

**Highlands Pediatrics PC**

**26210 Lee Hwy Abingdon VA 24211 Ph# 276-623-8100 Fax# 276-623-8126**

To have protected health information sent **TO** Highlands Pediatrics PC

1. Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Contact phone# (in case we have a question) \_\_\_\_\_

2. I hereby authorize the use or disclosure of my protected health information as describe below and understand and acknowledge the following:
- a. I am not required to sign this authorization and may in fact refuse to sign it.
  - b. Highlands Pediatrics PC will not condition treatment or payment for treatment on obtaining authorization from me, unless permitted by law.
  - c. I may inspect or copy the protected health information in question, as permitted by federal privacy regulations.
  - d. I have the right to revoke this authorization at any time. My revocation should be in writing and sent to the address above. My revocation will not affect any prior action taken as a result of the authorization.
  - e. If I have any questions about this authorization I may contact medical records at 276-623-8100.

3. This authorization applies to which protected information. **Be specific and mark all that apply.**  
All medical records \_\_\_\_\_ All medical records after the following date \_\_\_\_\_  
Vaccine records only \_\_\_\_\_ Records for the following specific date(s) \_\_\_\_\_  
Only specific records (please explain)  
\_\_\_\_\_  
\_\_\_\_\_

4. I understand that this information is to be used for (please check one)  
Treatment purposes \_\_\_\_\_ Other (please explain) \_\_\_\_\_

5. **FROM:** The following persons or organizations are authorized to release my protected health information. (please include name, address, phone#, and fax# if you have it available)
6. Unless I revoke this authorization in writing it will be valid for 6 months after the date below.
7. Use or disclosure of this information will result in direct or indirect compensation to Highlands Pediatrics PC.

**I certify that I have read and signed a copy of this authorization and may request a copy of it.**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Patient's Representative**

\_\_\_\_\_  
**Relationship to Patient**