Aardvark Pediatrics
www.aardvarkpediatrics.com
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Authorization to Release or Disclose Protected Health Information

Patient's Name: ___________________________________ Date of Birth: ______/______/______ Date of Request: ______________

Address: ____ Day Time Phone ___________________

Please list where **Aardvark Pediatrics** is to send medical records **TO** or where you would like us to request records **FROM**:

Facility/Office: ___________________________________ Fax Number: ___________________________________
Address: ____ Phone Number: ________________________________
City, State: _______________________________________ **Dates of Service:** _______________________________
Reason for request: ____________________________________

- ❏ **The following information is to be disclosed by Aardvark Pediatrics**: (Please check one box for each item if not requesting a complete record.)
- ❏ **The following information is to be sent to Aardvark Pediatrics:** (Please check one box for each item if not requesting a complete record.)

- ❏ Complete Record
- ❏ Well Visits
- ❏ Growth Chart
- ❏ Immunization Record
- ❏ Drug Allergy History
- ❏ Well Visits
- ❏ Problem List
- ❏ ADHD History
- ❏ Medication List

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.
Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.
Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing, and I understand the revocation will not apply to information already released based on this authorization.
Other Rights: a) I understand that authorizing the disclosure of this health information is voluntary and that I may refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.
Expiration: Unless otherwise revoked, this authorization will expire on the following date, event or condition: ________________. If I do not specify an expiration date, event or condition, this authorization will expire in 24 months from the date signed.

By signing this form, I understand and accept full responsibility for the medical records I am requesting. I relinquish Aardvark Pediatrics of any and all accountabilities concerning these medical records.

____
Signature of patient or legal representative Date

____
If signed by legal representative, relationship to patient