All Children's Clinic, PC AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

If any sections are incomplete this form may be invalid

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip: _____

RELEASE INFORMATION FROM:
All Children's Clinic, PC

Senatobia Office
103 Halls Cove
Senatobia, MS 38668
P: (662) 562-9003
F: (662) 562-4007

Southaven Office
3674 Goodman Rd E
Southaven, MS 38672
P: (662) 890-7747
F: (662) 890-3566

Hernando Office
930 Magnolia Hills Cove
Hernando, MS 38632
P: (662) 449-9230
F: (662) 449-9224

TO:
Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

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From:
Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

PURPOSE FOR THE RELEASE OF INFORMATION:

- ☐ Transferring to another Practice
- ☐ Attorney Use ☐ Personal Use
- ☐ Visit to Specialist
- ☐ Other (describe) _____

There is a fee for ACC to print and send records, this fee is waived if sending directly to another physician's office. This fee is determined by the state. Please call our medical records department to get current fee schedule.

DESCRIPTION OF INFORMATION BEING RELEASED:
Specific Date(s) of services:
From_____ To_____
I would like:

- ☐ An abstract (pertinent information related to the above listed date(s)
- ☐ Complete Health Record
- ☐ Billings Records
- ☐ Other: _____

SENSITIVE INFORMATION RELEASE:
I understand if my medical record or billing record contains information that references drug/alcohol abuse, psychiatric care, mental health treatment, HIV/AIDS, I agree to its release.
I hereby authorize All Children's Clinic, PC to use or disclose protected health information regarding my child's care and treatment. I understand that information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or state law.
I have the right to revoke this authorization at any time. I understand that my release shall not constitute a breach of my right to confidentiality. The authorization expires 90 days from the below date, and it covers only treatment prior to that date.

If the patient is 18 years of age or older, the patient must sign and date the form unless incapable of signing.
If the patient is 17 years of age or younger, a parent of legal guardian must sign and date the form.

Signature: _____ ☐ Self ☐ Parent/Guardian ☐ Other: _____

Date: _____/_____/_____