AdventHealth Ottawa

Authorization for Release of Confidential/Protected Health Information

Physician Practices of AdventHealth Ottawa

I, _____, born on_____
(Patient Name) *(Date of Birth)*

Patient's address_____

hereby authorize and request_____
(*Name of Hospital/Provider)*

To furnish to: **AdventHealth Ottawa Pediatric Care 1428 S Main St., Suite 3, Ottawa, KS 66067**

for the purpose of (specify reason for requesting release of information):_____

_____

the following information:

- ❑ Dictated reports
- ❑ Labs
- ❑ Imaging REPORTS
- ❑ Imaging FILMS
- ❑ Vaccine Record
- ❑ Progress Notes
- ❑ Entire Record from (date)_____to(date)_____
- ❑ Last Well Child Check
- ❑ Growth Chart
- ❑ Other_____

RESTRICTIONS: Only medical records that have originated from this facility will be photocopied unless otherwise requested. This authorization is valid only for the release of health information dated prior to and including the date the patient signed this authorization.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus(HIV). It may also include information about behavioral or mental health service, and treatment for drug and alcohol abuse.

This authorization is valid for the period of 60 days unless a different period is specified, not to exceed 1 year:

_____**(alternate period)**_____**(patient initials)**

_____ _____
Signature of Patient/Patient Representative ***Date Signed***

_____
Printed Name of Patient/Patient Representative

If patient representative, description of authority to act on behalf of the patient: _____

Address of Patient Representative:_____

Phone # of Patient Representative:_____

I understand that this authorization may be revoked at any time in writing, except to the extent it has already been acted upon. Once the uses and disclosures have been made pursuant to this authorization, they may be subject to re-disclosure by any recipient and no longer protected by the Federal Privacy Laws. Treatment or payment is not conditioned upon my providing authorization for this use or disclosure. I understand that I may inspect or copy the protected health information to be used or disclosed under this authorization. I understand that I may refuse to sign this authorization.

Prohibition on Re-disclosure: This information is released for the above purpose only, and has been disclosed to you from records whose confidentiality is protected by Federal regulations and is not to be re-released without a new authorization/consent by the person (or legal representative) to whom it pertains. A general authorization for the release of medical or other information, if held by another party, is not sufficient for this purpose (42 CFR Part 2).