Pediatric Neurology

420 Lowell Drive, Suite 201 • Huntsville, AL 35801 • (256) 265-1775

132 REQUEST FOR HEALTH INFORMATION FROM HOSPITALS OR OTHER PROVIDERS

Name of Organization/Person: _____

Address_____

Fax/Phone_____

Huntsville Hospital Pediatric Neurology Requests Information for the Following Patient:

Patient Name _____ SS# (Optional)_____

Date of Birth _____

Address _____

Phone _____ Date of Service_____

Patient Number

Requested information for treatment, payment, or operations:

- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Operative Note
- ☐ Pathology Report
- ☐ Consultation Report
- ☐ EKG Report
- ☐ Nurses' Notes
- ☐ Progress Notes
- ☐ Physicians' Orders
- ☐ Outpatient Record
- ☐ Emergency Dept Record
- ☐ Laboratory Results
- ☐ Imaging Results
- ☐ Other_____

_____

_____

_____

_____

_____

_____

Please fax or send to:

Huntsville Hospital Pediatric Neurology: Fax (256) 265-1780

420 Lowell Drive, Suite 201 Huntsville, Alabama 35801

Signature: _____ **Date**_____

Relationship to Patient: _____

Witness: _____

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name _____ SS Number (Optional)_____

Date of Birth _____ Address _____

Phone Number (_____)_____Date(s) of Service_____

Chart Number_____
Provider _____

I authorize the use or disclosure of the above named individual's health information as described below:

1. Huntsville Hospital Physician's Network is authorized to make the disclosure.

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- ☐ All /Entire Record
- ☐ Visit/Encounter Notes
- ☐ Laboratory Results
- ☐ X-Ray and Imaging Reports
- ☐ Problem list
- ☐ Medication List
- ☐ Allergies List
- ☐ EKG Report
- ☐ Pathology Report
- ☐ Consultation Report
- ☐ Operative Report
- ☐ Immunization Record
- ☐ Drug and Alcohol Treatment
- ☐ HIV/AIDS/STD Treatment
- ☐ Registration Record
- ☐ Other _____

☐ **Records Release Format (Choose one)**
- ☐ **e-delivery (HealthPort Connect)**
- ☐ **CD**
- ☐ **Paper**

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

4. This information may be disclosed to, and used by, the following individual or organization:

   Name: _____

   Address: _____

5. For the purpose of _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. Unless otherwise revoked, the authorization will expire on the following date, event, or condition:

   _____

   If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date of signing.

8. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

9. I understand that as the recipient, I am responsible for the security of these medical record copies and the health information contained therein, whether in paper format or on CD/DVD.

10. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.

Or

I understand that if I refuse to sign this form, under specific conditions the organization can refuse:
Treatment Enrollment in the health plan Eligibility for benefits

_____ _____ _____
SIGNATURE DATE TIME

_____ _____ _____ _____
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT SIGNATURE OF WITNESS DATE TIME

For Office Use Only

Any portion of the record request found in paper chart? YES NO (Please circle one)

HealthPort®

MEDICAL RECORD REPRODUCTION FEES FOR PATIENTS

To ensure that your medical records are kept confidential and private, it is necessary for you to authorize release of your records and provide proof of identity.

If medical records are needed for continuing care, there is no charge when records are *faxed* directly to your physician or the facility providing treatment. All other patient requests will typically result in fees for the patient.

Fees for Patient Request:

- **$.20 per page for all pages**
- **U. S. Mail charges as applicable**
- **No charges to veterans or active duty military with military identification**

Walk-in requests will generally be processed within 5-7 business days.

If your records are needed for treatment or for an appointment within the next 48-72 hours, your physician can request your records by fax when you arrive in his/her office for treatment. (Records can be faxed to the physician's office at no charge to the patient.)

HealthPort, Inc. provides Release of Information services for Huntsville Hospital

By signing below, I acknowledge that I was informed of the fees required to obtain copies of my medical records.

Patient Name: _____

Patient Signature: _____
(Or signature of personal representative)

Date: _____

Patient's Date of Birth: _____

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112 LEGALLY AUTHORIZED REPRESENTATIVE DESIGNATION

Patient Full Name: _____
(Name of a minor child or patient who is physically/mentally incapacitated or deceased.

Date of Birth: _____ **SS#** (Optional / Last 4 digits)_____

PATIENT IS A MINOR CHILD OR IS PHYSICALLY OR MENTALLY INCAPACITATED:

The following classifications are in order of priority. Please check the applicable classification:

1. _____ A court-appointed guardian or a guardian appointed by a person legally authorized to appoint a guardian under the statute.

2. _____ An agent appointed by the patient in accordance with an Advance Directive, Living Will and/or a Durable Power of Attorney for health care.

3. _____ Spouse of patient (including common law spouse).

4. _____ Son or daughter nineteen (19) years or older of the patient.

5. _____ Parent of the patient. □ Mother □ Father

6. _____ Brother or sister aged nineteen (19) or older of the adult patient.

7. _____ Any one of the patient's surviving adult relatives who are of the next closest degree of kinship to the patient. Specifically, I am the _____.

Signature _____Date_____Time_____

By checking one of the above, I hereby certify that I am the legally authorized representative of the named minor child or incapacitated person and to my knowledge, there is no person with a higher classification. I thereby am authorized to receive or to request medical records on behalf of the above named person.

PATIENT IS DECEASED:

1. _____ Executor/administrator of the estate

2. _____ Family member or other who was involved in care or payment for care of the decedent prior to death.

Signature _____Date_____Time_____

By checking one of the above, I hereby certify that I am the executor or administrator of the estate or was involved in the care or payment for care of the decedent prior to death. I thereby am authorized to receive or to request medical records on behalf of the above named person.

Print name: _____ Phone Number:_____

Address: _____City, State, & Zip Code _____

_____ _____ _____
Witness' Signature Date Time

Reviewed: August 2000, Revised: July 2005, April 2013, March 2014
FORM # NS 285850

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