The Doctors Luce Pediatrics, LLC

Authorization for Release of Protected Health Information

** ONE PATIENT PER REQUEST FORM. EACH PATIENT REQUEST IS TO BE MADE SEPARATELY **

Pricing and Pick-Up Information for Patients:

- S HIPAA guidelines define patient records as protected and cannot be disclosed without written permission.
- S Patients may have a copy of their complete medical records for $50. The same fee applies to third-parties, such as attorneys and insurance companies. There is no reduction of fees for partial records.
- S Doctor to doctor releases are done without charge. All other requested reasons carry a charge.
- S Please allow 4-5 business days to prepare requested records for their intended destination.
- S **An additional $25.00 charge for same day requests (records received within 24 hours) will be assessed.**
- S **All areas must be filled out for personnel to assist you in your request for records.**
- S **ID Check And Full payment for records required at pick-up.**

Requested By:

Name of Patient _____ Medical Record#_____
Address _____ Phone #_____
City, State, Zip _____ SSN_____
Date of Birth _____

Please choose from options 1 - 3

□ **1. Requesting Prior Medical Records To Be Sent To TDLP**

Information Requested:	**For Which Date(s):**	**For Which Doctor(s):**
□ Lab Reports	_____	_____
□ Imaging Reports	_____	_____
□ Office Visit Notes	_____	_____
□ Immunizations	_____	_____
□ Operative Notes	_____	_____
□ History & Physical	_____	_____
□ Other _____	_____	_____

□ **2. TDLP Records To Be Released To Another Clinic/Institution ($50 Fee Applies to Third-Parties)**

Name_____ Phone #_____
Address_____ Fax#_____
City, State, Zip_____ Date Records Required_____

□ **3. I Want To Have My Own Copy Of Medical Records ($50 Fee Applies)**

I hereby release the above-named facility or doctor(s) from all legal liability that may arise from the release of this information. I acknowledge that records to be released may include material that is protected by Federal Regulation 42 CFR, Part 2, including AIDS/AIDS Testing information, drug/alcohol information, and mental health information. My signature below authorizes the release of all information. A separate authorization is generally required with each release.

_____ _____
Signature of Patient Requesting Records (or representative if a minor)

Signature of Patient Receiving Records (or representative if a minor)
(Please sign UPON RECEIPT of records)

_____ _____
Print Name of Patient or Representative

Date of Receipt

_____

Type of I.D. Checked: ♦ D.L. ♦
Other_____

Date of Request

_____ _____
Witness (For Clinic Use)

Signature of Clinic Staff Issuing Records