Meridian Pediatrics

12065 Old Meridian Street, Suite 100
Carmel, IN 46032
(317) 844.5351
(317) 844.0310 (FAX)
www.meridianpediatrics.net

Authorization for Release of Patient Health Information

Patient Name:	Patient Date of Birth:
Address:	
City / State / Zip:	
Telephone #:	

I hereby authorize the protected health information regarding the above-named person to be exchanged between:

From:	**To:**
Person / Institution:	Person / Institution:
Address:	Address:
City:	City:
State / ZIP:	State / ZIP:
Telephone #:	Telephone #:

Method of Record delivery, choose 1 option:

☐ FAX (Please provide FAX number. 25 pages or fewer only.)	☐ USB Drive
☐ Pick Up Printed Copy	☐ CD Copy

Information will be used for the following purpose:

☐ ***Not Transferring Out of Practice:***	☐ ***Transferring Out of Practice (please specify):***
☐ My personal use (there is a fee for personal use copies)	☐ Moving ☐ Aged-Out ☐ Insurance ☐ Dissatisfied
☐ *Other (please specify)*	

Select the type of information to be used or disclosed

☐ Complete Pediatric Record Release: consultation reports, lab reports and test results; complete vaccination record and growth chart. Additionally, this includes a health history summary of medical and surgical history.

☐ Pediatric Record Release: consultation reports, lab reports and test results; complete vaccination record and growth chart. Additionally, this includes a health history summary of medical and surgical history.

Unless otherwise specified here: From:_____ To:_____

The following highly confidential items must be checked off to be included in the use or disclosure of other health information:

☐ Genetic testing information and/or records ☐ Information about child abuse and neglect

PATIENT 18 YEARS or OVER MUST AUTHORIZE THIS RELEASE BY CHECKING THE BOX BELOW AND SIGNING:

☐ HIV/AIDS related health information and/or records

☐ Behavioral or mental health information and/or records *(Release must be witnessed, Patient 18 or over must authorize)*

☐ Information about sexually transmitted disease ☐ Pregnancy ☐ Birth control ☐ Drug/alcohol diagnosis, treatment, and/or referral information

This authorization will expire in 30 days

_____ _____
Printed Name of Patient or Legal Guardian **Relationship**

_____ _____
Signature of Name of Patient or Legal Guardian **Date**

*(For information regarding Mental Health, HIV/AIDS, Drug and Alcohol, Sexually Transmitted Diseases, Pregnancy and Birth Control **the patient 18 years old or over must sign** to release these records)*

For Mental Health Releases Only:

_____ _____
Witness / Interpreter **Date**
(Mental health releases must be witnessed)

Meridian Pediatrics

12065 Old Meridian Street, Suite 100
Carmel, IN 46032
(317) 844.5351
(317) 844.0310 (FAX)
www.meridianpediatrics.net

Authorization for Release of Patient Health Information

Unless revoked, this authorization will expire 30 days from the date of signature on the authorization or from the date noted above. For mental health purposes this authorization will expire one year form the date of signature.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment; except, however, if my treatment is for the sole purpose of creating health information for disclosure to the recipient identified in the Authorization, in which case Meridian Pediatrics of Carmel Indiana may refuse to treat me if I do not sign this Authorization.

I understand that once Meridian Pediatrics discloses my health information to the recipient, Meridian Pediatrics cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and Indiana law governing the use and disclosure of my health information.

I understand that I have the 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 Meridian Pediatrics Health Information Management 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.

I understand that Meridian Pediatrics may, directly or indirectly, receive remuneration from a third party in connection with the use and disclosure of my health information.

I understand that I have the right to inspect and obtain a copy of any information about mental health, drug and alcohol, or developmental disability services that is disclosed pursuant to this Authorization.

I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Meridian Pediatrics to use or disclose my health information in the manner described above.