WholeKids PEDIATRICS

Request for medical records

HIPPA Compliant Request for Information

1. **My Information**:

Patient Name:	Address:
Phone:	City/State/Zip:
Email Address:	Date of Birth:

2. **Custodian Information**: I hereby give the following entity permission to release my Protected Health Information (PHI):

Name: WHOLEKIDS PEDIATRICS	Address: 1335 DUBLIN RD. SUITE 114E
Phone: 614-298-5437 Fax: 614-299-2467	City/State/Zip: COLUMBUS, OH 43215

3. **Information Requested**: I instruct the above entity to release a copy of the following information (Check One):

___Medical Summary/Vaccines Only ___Entire Record ___Specific Record(s):

_____

Name:	Address:
Phone: Fax:	City/State/Zip:

Where to send: I am requesting the above designated records be released to the following entity or person:

4. **Form & Format of Records**: I request the copies of records be delivered as follows (Check One):

X	Form	Format		Method of Delivery
	Electronic	CD	$25	Mailed to the address indicated above
	Electronic	Fax	$40	Fax the record to the number indicated above
	Hard Copy	Paper	$40	Mailed to the address indicated above

6. **Reason for Disclosure**: I am requesting my PHI to be disclosed for the following purpose:

_____

7. **Sensitive Information Disclosure**: HIV, Behavioral Health, or Drug and Alcohol Abuse/Treatment information within the dates specified above ***are to be released*** through this authorization unless otherwise checked below:

   DO NOT RELEASE: (Check all that apply) ___HIV ___Behavioral Health ___ Drug/Alcohol

   This authorization is valid for 90 days. I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this Authorization. I am entitled to a copy of this authorization upon my request. I may not be required to sign this Authorization as a condition of obtaining treatment or payment or my eligibility for benefits. The recipient of this protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically requited or permitted by law. Where permitted, the information I am requesting to be disclosed may sometimes be re-disclosed by the recipient and may no longer be protected by law. I am entitled to notice if my PHI is used for marketing and results in remuneration to the provider. I hereby acknowledge that I have read and fully understand the above statement as they apply to me.

   _____ _____

   Signature of Patient or Parent/Legal Guardian Date