SUSAN L. FIELD, MD, FAAP
SCOTT S. FIELD, MD, FAAP

Field Pediatrics P.C.

1106 GLENEAGLES DRIVE
HUNTSVILLE, ALABAMA 35801

256-881-WELL

Authorization to Release Medical Information

Patient's Name(s) (please print) Patient's Date(s) of Birth

_____ _____

_____ _____

_____ _____

Source of records: _____

Field Pediatrics, PC **or** _____

_____

Bulky electronic health records preferred by CD

☐ Please release the entire record **or** ☐ Please release the following:

☐ Problem sheet/ record summary ☐ Record of immunizations

☐ Progress notes, sick visits, and check-up visits (up to 20 pages)

☐ Hospital records ☐ Lab tests, X-rays, and other test results

☐ Consultations ☐Other_____

This information is released to: Field Pediatrics, P.C., above address, Fax # 256-881-5084

Or _____

Phone # _____ Fax # _____

Please initial each item below to indicate your understanding.

_____ Due to time involved reviewing and organizing extensive (over 30 pages) medical records, I will pay for this service ($25 for 31-50 pages, up to $70 for 126-150 pages).

_____ I understand that the information in this health record may include sensitive information such as behavioral and mental health issues, sexual, and/or drug issues.

_____ I understand that once the information is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand that I have a right to revoke this authorization (except for the health insurance company) at any time as long as a written revocation is provided to this office prior to actual release of records.

This authorization will expire in 12 months or _____ (specified less than 12 months)

Signed by: ☐ Parent ☐ Legal guardian ☐ Patient _____ Date _____

Signature