900 South 52nd Street, Suite 200
Rogers, AR 72758
Ph: 479-254-1100 Fax: 479-254-2997

Medical Records Release Form

This Authorization for Release of Health Information relates to the following patient (“Patient”):

Patient Name: ____ DOB: ______/______/_______

Patient SSN: ____

I, the undersigned parent, guardian, authorized representative and/or patient identified herein, do hereby authorize Harvey Pediatrics, PLLC (“Provider”) to disclose any and all of the individually identifiable health information of the Patient as described below *[to be completed by requesting party]*:

☐ Complete Record ☐ Shot Record ☐ Other _________________

I authorize release of this information to *[to be completed by requesting party]*: ___________________________________

____

I authorize release of this information via ______ fax _________email _______ pick up

Purpose of Disclosure: ___Continuing Medical Care ___Insurance ___Social Security/Disability ___Daycare/School
___Legal ___Motor Vehicle or other Accident Other: ____________________

This release / request is made at the request of the Patient or authorized representative of the Patient and was initiated by the Patient or the Patient’s authorized representative. *[If the Patient or authorized representative does not initiate the request, then consult counsel.]*

I understand that once the information described herein is disclosed, there is a potential that the information may be further disclosed and no longer protected by federal privacy laws and regulations. I further understand that the Provider furnishing the copies may be compensated for copying charges incurred for disclosing this information, and I have been made aware of the records request charge policies of the Provider.

I further understand that this Authorization is voluntary and that I may refuse to sign this Authorization. Unless allowed by law, my refusal to sign this Authorization will not affect my ability to obtain treatment, receive payment or eligibility for benefits.

I understand that I may revoke this Authorization at any time by giving written notice to the Provider at the following address: 900 South 52nd Street, Suite 200, Rogers, AR 72758. Notwithstanding the foregoing, a revocation of this Authorization will not apply to records and information already released in reliance upon the Authorization.

I understand requests for records to be sent to a third party (attorney, insurance company) can only be completed with a request and authorization directly from that party.

If you desire records for your own personal use, the records will be copied and available at the front desk and the following fees will apply. Medical records will not be mailed. The fees will be collected prior to the release of the medical records.

$15.00 processing fee .50 (fifty cents) per page for pages 1-25 .25 (twenty five cents) per page for any additional page

This authorization will expire six (6) months from the date signed below. A photocopy of this signed Authorization shall constitute a valid Authorization.

____ ______________________________
(Signature of Patient or Authorized Representative) (Date)

____ ______________________________
(If an authorized representative, indicate authority) Witness

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Office use only:

Account #: ______________ Verified Identification: ___________ Date records released: ____________