AUTHORIZATION TO OBTAIN OR RELEASE PROTECTED HEALTH INFORMATION

Rainbow Kids Clinic
111 Otis Smith Drive
Clarksville, TN 37043
Phone (931) 553-6666, Fax (931) 553-6681

I, ____

Address: ____

City: ______________________________ State______________ Zip_________

Phone: _______________________________ Cell/Wk: ____________________

Hereby authorize Rainbow Kids Clinic to: ____Release Copies ____Obtain Records

Protected Health Information of:

____ DOB: _______________

____ DOB: _______________

____ DOB: _______________

____ DOB: _______________

This request and authorization applies to:

____ Immunization Records ____ Other ______________________________

____ All Records: All of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, ADHD, autism, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released:

___Substance abuse ___ Psychological or psychiatric treatment __HIV/AIDS/STD

Send Records to/Get Records From: ____

Address: ____

City: __________________________ State_____________ Zip_____________

Phone: _________________________ Fax: ____________________________

Reason for Release of Records: ☐Selecting New Physician ☐Consult ☐Personal
☐Relocating Out of Town (if relocating, please provide forwarding address/phone)

☐Other____

I understand that this information will not be disclosed to any other agency or individual without my written authorization, except as allowed by law. I also understand that my protected health information, which is disclosed with this release, may be subject to re-disclosure by the recipient and no longer protected by law. Rainbow Kids Clinic is not responsible for any alterations made on its medical record copies, which have been released to any party.

I understand that I have a right to a copy of this authorization after I sign it and that Rainbow Kids Clinic will not condition any provision of treatment on my signing this authorization.

This authorization expires one year after the date I sign it. I understand that this authorization may also be revoked at any time with my written statement.

____ _________________

Parent or Guardian Signature Date