Rainbow Children's Clinic
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Authorization to Release Health Information

Patient Information:

Name of Patient ____ Date of Birth __________________

Address ____

City, State, Zip ____ Phone _________________________

Name of Releasing Facility:	***Send Records to:***
Name:	Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone:	Phone:
Fax:	Fax:

*** **MEDICAL RECORDS THAT EXCEED 25 PAGES MUST BE RECEIVED BY MAIL ONLY. PLEASE DO NOT FAX**

*** **DISC FILES MUST BE IN TIF OR JPEG FORMAT ONLY**

INFORMATION TO BE RELEASED

☐ IMMUNIZATION RECORD ONLY *** **PLEASE FAX SHOT RECORD AS SOON AS POSSIBLE**

☐ MEDICAL RECORDS – Date Range:___________________ to ____________________ ☐ ALL RECORDS

☐ TEST RESULTS: TYPE OF TEST:____________________ Date___________________ ☐ ALL TESTS

☐ OTHER ____

This authorization will expire after request is fulfilled and shall not extend beyond 180 days from the date of signature.

Patient Rights:

- I may refuse to sign this authorization and I have the right to revoke this authorization at any time.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I understand released health record may contain information in reference to Hepatitis B or C testing, HIV testing and or other sensitive information.
- I understand that if I wish to have copies made, then the facility may assess a fee for copying the records. I will be notified of the total amount due for copying and shipping the requested records. I agree that the facility will only send me the requested information once it has received payment in full for those costs. I may inspect or copy the protected health information to be disclosed as described in this document

____ Date ____________________________

Signature of Person Making the Request

Print Name ____ Relationship to Patient_________________________