Revised 11/2024

40920 US HWY 280
Sylacauga, AL 35150
Phone: 256-208-0060
Fax: 256-208-0755

398 Chesser Dr. Suite 7
Chelsea, AL 35043
Phone: 205-678-1286
Fax: 205-618-9696

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:_____

Address: _____

Phone Number:_____ Date of Birth:_____

This Authorization applies to the following information:

☐ All Information/ Complete Medical Records

I understand that the information may contain psychiatric/phycological, alcohol/drug abuse, AIDS/HIV information, and/or other sensitive health information and I expressly consent to the release of that information. This authorization will expire in 90 days.

☐ Only the following records or types of information:_____

Treatment Dates: From (____/____/____) to (____/____/____)

The information may be released as follows:

☐ From Pathway Pediatrics Inc.
40920 US HWY 280
Sylacauga, AL 31510

To: _____
_____
_____

OR_____

☐ From:_____
_____
_____

☐ To: Pathway Pediatrics, Inc.
398 Chesser Dr, Suite 7
Chelsea, AL 35043
Fax: (205) 618-9696

☐ To: Pathway Pediatrics, Inc.
40920 US HWY 280
Sylacauga, AL 35150
Fax: (256) 208-0755

Purpose of the release:

Continuity of Treatment Other (Please specify):_____

I understand the information released will be limited to information necessary to fulfill the need or purpose for the disclosure. If I have authorized the disclosure of Information to a recipient who is not subjected to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), then the recipient may re-disclose it and may no longer be protected under HIPAA, a federal privacy law. This Authorization is valid for ninety days from the date of signature, unless otherwise noted. This Authorization only applies to treatment occurring before the date of signature. I may decline to sign this Authorization. I understand I may revoke this authorization in writing at any time. If I revoke this authorization, the revocation will not apply to information that has already been released in response to this authorization. I understand the patient's health care and the payment for the patient's health care will not be affected if I do not sign this form. I understand I may see and copy the information described on this form if I ask for it, and I may receive a copy of this form after I sign it. Before requesting medical records copies, please ask about the coy fee by law that may apply. I represent that I have the authority to voluntary grant permission for the information to be released as described above.

_____ _____

(Patient/Parent/Legal Guardian Printed Name) (Patient/Parent/Legal Guardian Signature) Date

_____

(Witness Signature for Patient/Parent/Legal Guardian) Date