



# Authorization for Release of Information For Purpose of Continuity of Care

**Jeff Malone, MD**  
**Alice Hardy, MD**

**Please release**  All information in medical record (I understand that the information may contain psychiatric/psychological, alcohol/drug abuse, AIDS/HIV information, as well as other sensitive health information, and I expressly consent to the release of all information.)

Only the following types of information: \_\_\_\_\_

**To South Trace Pediatrics**  
**5330 Stadium Trace, Suite 150**  
**Hoover, AL 35244**  
**Phone 205-985-9424**  
**Fax 205-985-9465**

**From** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**Phone** \_\_\_\_\_  
**Fax** \_\_\_\_\_

**For the following patients:**

**Name** \_\_\_\_\_ **DOB** \_\_\_\_\_

**Name** \_\_\_\_\_ **DOB** \_\_\_\_\_

**Name** \_\_\_\_\_ **DOB** \_\_\_\_\_

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 or information to a recipient who is not subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), then the recipient may re-disclose it and it may no longer be protected by HIPAA, a federal privacy law. This authorization is valid for ninety (90) days from the date of signature, unless otherwise noted. The authorization only applies to treatment occurring before the date of the signature. I may decline to sign this authorization. I understand that I may revoke the 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 that 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 that I may see and copy the information described on this form if I ask for it, and I may receive a copy after I sign it. Before requesting copies of medical records, please ask about the copy fee that by law may apply. I represent that I have the authority to and voluntarily grant permission for the information to be released as described above.

\_\_\_\_\_  
Patient/Parent/Legal Guardian Printed Name

\_\_\_\_\_  
Parent/Legal Guardian Signature      Date

\_\_\_\_\_  
Patient Signature if over age 14 years

\_\_\_\_\_  
Witness to Signature of Patient/  
Parent/Legal Guardian      Date