



HUNTSVILLE HOSPITAL

PEDIATRIC NEUROLOGY

401 LOWELL DRIVE SUITE 5 • HUNTSVILLE, AL 35801 • (256) 265-1775

# 132 REQUEST FOR HEALTH INFORMATION FROM HOSPITALS OR OTHER PROVIDERS

Name of Organization/Person: \_\_\_\_\_

Address \_\_\_\_\_

Fax/Phone \_\_\_\_\_

Huntsville Hospital Pediatric Neurology Requests Information for the Following Patient:

Patient Name \_\_\_\_\_ SS# (Optional) \_\_\_\_\_

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Date of Service \_\_\_\_\_

Patient Number

Requested information for treatment, payment, or operations:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Discharge Summary    | <input type="checkbox"/> Consultation Report | <input type="checkbox"/> Outpatient Record     |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> EKG Report          | <input type="checkbox"/> Emergency Dept Record |
| <input type="checkbox"/> Operative Note       | <input type="checkbox"/> Nurses' Notes       | <input type="checkbox"/> Laboratory Results    |
| <input type="checkbox"/> Pathology Report     | <input type="checkbox"/> Progress Notes      | <input type="checkbox"/> Imaging Results       |
|   | <input type="checkbox"/> Physicians' Orders  | <input type="checkbox"/> Other _____           |

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please fax or send to:

**Huntsville Hospital Pediatric Neurology: Fax (256) 265-1780**

**401 Lowell Drive, Suite 5 Huntsville, Alabama 35801**

Signature: \_\_\_\_\_

Date \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Witness: \_\_\_\_\_



ROI32A



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### AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name \_\_\_\_\_ SS Number (Optional) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Address \_\_\_\_\_

Phone Number (\_\_\_\_\_) \_\_\_\_\_ Date(s) of Service \_\_\_\_\_

Chart Number \_\_\_\_\_  
Provider \_\_\_\_\_

I authorize the use or disclosure of the above named individual's health information as described below:

- 1. Huntsville Hospital Physician's Network is authorized to make the disclosure.
2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)
- All /Entire Record
- Visit/Encounter Notes
- Laboratory Results
- X-Ray and Imaging Reports
- Problem list
- Medication List
- Allergies List
- EKG Report
- Pathology Report
- Consultation Report
- Operative Report
- Immunization Record
- Drug and Alcohol Treatment
- HIV/AIDS/STD Treatment
- Registration Record
- Other
- Records Release Format (Choose one)
- e-delivery (HealthPort Connect)
- CD
- Paper
3. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
4. This information may be disclosed to, and used by, the following individual or organization:
Name: \_\_\_\_\_
Address: \_\_\_\_\_
5. For the purpose of \_\_\_\_\_
6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
7. Unless otherwise revoked, the authorization will expire on the following date, event, or condition:
If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date of signing.
8. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.
9. I understand that as the recipient, I am responsible for the security of these medical record copies and the health information contained therein, whether in paper format or on CD/DVD.
10. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.
Or
I understand that if I refuse to sign this form, under specific conditions the organization can refuse:
Treatment Enrollment in the health plan Eligibility for benefits

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_ TIME \_\_\_\_\_
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT \_\_\_\_\_ SIGNATURE OF WITNESS \_\_\_\_\_ DATE \_\_\_\_\_ TIME \_\_\_\_\_

\*For Office Use Only\*

Any portion of the record request found in paper chart? YES NO (Please circle one)



## MEDICAL RECORD REPRODUCTION FEES FOR PATIENTS

To ensure that your medical records are kept confidential and private, it is necessary for you to authorize release of your records and provide proof of identity.

If medical records are needed for continuing care, there is no charge when records are *faxed* directly to your physician or the facility providing treatment. All other patient requests will typically result in fees for the patient.

### **Fees for Patient Request:**

- **\$.20 per page for all pages**
- **U. S. Mail charges as applicable**
- **No charges to veterans or active duty military with military identification**

Walk-in requests will generally be processed within 5-7 business days.

If your records are needed for treatment or for an appointment within the next 48-72 hours, your physician can request your records by fax when you arrive in his/her office for treatment. (Records can be faxed to the physician's office at no charge to the patient.)

HealthPort, Inc. provides Release of Information services for Huntsville Hospital

By signing below, I acknowledge that I was informed of the fees required to obtain copies of my medical records.

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_  
(Or signature of personal representative)

Date: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_



HUNTSVILLE HOSPITAL

PEDIATRIC NEUROLOGY

101 SIVLEY ROAD • HUNTSVILLE, AL 35801 • 256-256-1000

112 LEGALLY AUTHORIZED REPRESENTATIVE DESIGNATION

Patient Full Name: (Name of a minor child or patient who is physically/mentally incapacitated or deceased.)

Date of Birth: SS# (Optional / Last 4 digits)

PATIENT IS A MINOR CHILD OR IS PHYSICALLY OR MENTALLY INCAPACITATED:

The following classifications are in order of priority. Please check the applicable classification:

- 1. A court-appointed guardian or a guardian appointed by a person legally authorized to appoint a guardian under the statute.
2. An agent appointed by the patient in accordance with an Advance Directive, Living Will and/or a Durable Power of Attorney for health care.
3. Spouse of patient (including common law spouse).
4. Son or daughter nineteen (19) years or older of the patient.
5. Parent of the patient.
6. Brother or sister aged nineteen (19) or older of the adult patient.
7. Any one of the patient's surviving adult relatives who are of the next closest degree of kinship to the patient.

Signature Date Time

By checking one of the above, I hereby certify that I am the legally authorized representative of the named minor child or incapacitated person and to my knowledge, there is no person with a higher classification. I thereby am authorized to receive or to request medical records on behalf of the above named person.

PATIENT IS DECEASED:

- 1. Executor/administrator of the estate
2. Family member or other who was involved in care or payment for care of the decedent prior to death.

Signature Date Time

By checking one of the above, I hereby certify that I am the executor or administrator of the estate or was involved in the care or payment for care of the decedent prior to death. I thereby am authorized to receive or to request medical records on behalf of the above named person.

Print name: Phone Number:

Address: City, State, & Zip Code

Witness' Signature Date Time

