LENTZ PEDIATRICS

10777 Hwy 412 West
Lexington, TN 38351
Phone 731-968-5558
Fax 731-968-5567

19 Security Drive
Jackson, TN 38305
Phone 731-664-9040
Fax 731-664-9041

HIPAA Authorization for Release of Protected Health Information

This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) and applicable Tennessee law governing the disclosure of medical records.

Patient Information

Patient Name: _____
Date of Birth: _____
Parent/Legal Guardian: _____

Authorization

I authorize Lentz Pediatrics and its workforce members to use and/or disclose the protected health information (PHI) identified below.

Release Records **FROM**:
Facility/Provider: _____
Address: _____
Phone: _____ Fax: _____

Release Records **TO**:
Facility/Provider: _____
Address: _____
Phone: _____ Fax: _____

Information to be Released

☐ Complete Medical Record
☐ Immunization Records
☐ Well Child Visits
☐ Growth Charts
☐ Laboratory Results
☐ Radiology Reports
☐ Medication Records
☐ Billing Records
☐ Other: _____

Purpose of Disclosure

☐ Continuing Medical Care
☐ Personal Use

☐ Insurance
☐ School
☐ Legal
☐ Other: _____

Tennessee and HIPAA Acknowledgments

I understand and acknowledge the following:

• This authorization is voluntary.
• I may revoke this authorization at any time by submitting a written revocation to Lentz Pediatrics, except to the extent action has already been taken in reliance on it.
• Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
• Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.
• If this authorization includes records that receive special protection under federal or Tennessee law, including mental health, substance use treatment, HIV/AIDS-related information, or other specially protected records, those records will only be released if specifically authorized below.

Specially Protected Information

By initialing below, I specifically authorize the release of the following information if contained in the record:

Mental Health Records: _____
Substance Use Treatment Records (42 CFR Part 2, if applicable): _____
HIV/AIDS-Related Information: _____
Other Specially Protected Information: _____

Expiration

This authorization will expire in 1 year from date of signature *unless another date* is specified:_____

Signature

Patient Signature:_____ OR
Parent/Legal Guardian Signature: _____
Relationship to Patient: _____
Date: _____

For Office Use Only:
Date Request Received: _____
Date Records Released: _____
Released By: _____