HATCH!
PEDIATRICS

**280 W Kagy Blvd, Suite G • Bozeman, MT 59715**
**Phone: 406-587-5870 • Fax: 406-522-1536**

# Authorization for Release of Information

Patient Name:_____ Date of Birth:_____

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Records (circle one): REQUESTED FROM SENT TO

_____
Medical Practice Name

_____
Address

_____
City State Zip

Phone#_____ Fax#_____

**Purpose of Release:**

- Transfer primary care due to:
  - ☐ New primary care clinic
  - ☐ Out of town move
  - ☐ Insurance change
  - ☐ Consultation/Second Opinion

**Dates of Service:**

- ☐ All Dates of Service
- ☐ For the date ranges: _____ to _____
- ☐ For the following dates of services_____

**Specific Information Requested:**

- ☐ Entire Medical Record
- ☐ Vaccine Records
- ☐ Clinic visit notes, lab and x-ray results
- ☐ Other, specific information only (please explain)_____

By signing this authorization I give permission to release and transfer my child's protected health information to the above requesting doctor for the purpose of treatment. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the HIPAA Privacy Rule may no longer protect the information. I understand that Hatch Pediatrics will not condition the provision of treatment or payment on the provision of this authorization. Per the Notice of Privacy Policy, I understand I have the right to revoke this authorization is writing at any time. I understand that this authorization is in effect for one year from the date signed.

_____
**SIGNATURE** **DATE**

_____
**Printed Name** **Relationship to Patient**