If requesting records to The Youth Clinic, please contact that facility to send records to us as we are unable to request on your behalf.

Authorization to Disclose Protected Health Information

Patient Name: _____ DOB: _____

AUTHORIZATION

I authorize The Youth Clinic to release records to:

Name/Name of Facility_____

Address_____

Phone:_____Fax:_____

Secure Email:_____

Purpose of Request:

- Moving from area
- Legal
- Transitioning to Adult Provider
- Personal
- Other:_____

***We will only release records generated by our clinics. If needing records from other facilities, please contact them directly.**

PLEASE RELEASE THE FOLLOWING INFORMATION:

- **Basic Medical Records (**Immunization record, growth charts if applicable, office visits for the past two years)
- Just records related to specific illness, injury or disease: _____
- Other:_____
- Please let us know if you want to include records related to:
  - Psychological or psychiatric conditions (yes or no):_____
  - Alcohol and/or drug abuse (yes or no):_____
  - HIV/AIDS (yes or no):_____

A valid photo ID, of the legal guardian/parent or patient themselves if 18+ is required for release of medical records. Our turnaround time is typically 7 business days.

This authorization is valid for 90 days from the date of signature.

Patient Rights: I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). I understand that I have the 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 entity which was originally authorized to disclose information. Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____

Patient (if 18 years or older), Parent or Legal Guardian Signature Date

*Fees for Medical Records Requests copy services are as follows:
To Patient or Legal Guardian: My Health Connection and secure email delivery is free (all pages). Paper Delivery: 1-10 are free, 11-99 pages are $6.50, 100 or more pages delivered electronically only.
To Third Party recipient: $18.53 (retrieval fee for pages 1-10) plus $0.85 (each pages 11-40) plus $0.57 (each page over 40).

FOR CLINIC OFFICE USE ONLY (please transcribe information from Photo ID. A scanned copy of ID is not required)
MRN_____
Parent/Patient if over 18yr/ Legal Guardian's Driver's License/State ID/Military ID _____State_____
Release Taken and Reviewed By (first and last name)_____