Eastern Shore
DEVELOPMENTAL CLINIC

HIPPA AUTHORIZATION FOR RELEASE OF INFORMATION

PLEASE RETURN TO:

Eastern Shore Developmental Clinic LLC
28150 North Main St. Suite A
Daphne Al 36526
Phone: 251-625-2400 • Fax: 866-845-2618

Patient Name (Last, First, MI):_____

Address: _____

Phone Number: _____ Date of Birth: _____

This Authorization applies to the following information:

I understand that the information may contain psychiatric/psychological, alcohol/drug1 abuse·, HIV/AIDS information, and/or other sensitive heath information and I expressly consent to the release of the following information:

☐ Social Service Records	☐ Treatment Plan	☐ Referral/Treatment Summary
☐ Progress Notes	☐ Psychological Testing Results	☐ Discharge Summary
☐ Medication History	☐ Patient Demographic Information	☐ Admission Evaluation
☐ School correspondence (nurse, ect.)	☐ ALL Records	☐ Other (Specify): _____

Treatment Dates: from (month/day/year) _____/ _____/ _____ to (month/day/year) _____/ _____/ _____

The Information may be released as follows:

(Please check FROM whom the Information is released and TO whom it goes)

☐ **From OR** ☐ **To** Eastern Shore Developmental Clinic (Specify: _____)

Address/Phone Number: 28150 North Main St, Suite A, Daphne, AL 36526 • 251.625.2400

☐ **From OR** ☐ **To** External Individual/Agency/Organization (Specify:_____)

Address/Phone Number: _____

Purpose of the Release:

☐ Continuity of Treatment ☐ Other (Please specify): _____

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 of information to a percipient who is not subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), then the recipient may re-disclose it and it may no longer be protected under HIPPA, a federal privacy law. This Authorization is valid for ninety (90) days from the date of signature, unless otherwise noted. This Authorization only applies to treatment occurring before the date of signature. I may decline to sign this Authorization. I understand I may revoke this authorization in writing at any time by completing a form available from Medical Information Services. If I revoke this authorization, the revocation will not apply to information that has already been released in response to this authorization. I understand 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 I may see and copy the information described on this form if I ask for it, and may receive a copy of this form after I sign it. Before requesting medical record copies, please ask about the copy fee law that 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 14 or older | Date | Witness Signature for Patient/Parent/Legal Guardian | Date