RAINBOW PEDIATRICS
1224 GRAHAM ROAD, SUITE 3009
FLORISSANT, MISSOURI 63031
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FAX (314) 839-8545

RELEASE OF INFORMATION

Authorization for Use of Disclosure of Information for Purposes Requested by Physician's Office

I, ____________________________________, hereby authorize Rainbow Pediatrics to disclose/receive the following protected health information to/from: ____
____
____
____

This includes: ( ) Immunization Record ( ) Growth Grid ( ) X-Ray Reports ( ) Lab Reports
( ) Pathology Reports ( ) Operative Reports ( ) Consultation Letters ( ) H&P Exam
( ) Progress Notes ( ) Psychotherapy Notes/Consults
( ) Charges/Payments ( ) Hospital Records/ER Reports
( ) All of the above ( ) Other ____

This applies to the following dates of service: From ____________________ To ____________________

This Protected Health Information is needed for: continuity of care, or: ____________________________
____

List Children: ____ Birthdate: ________________________
____ Birthdate: ________________________
____ Birthdate: ________________________
____ Birthdate: ________________________

Patient/Parent/Guardian (Circle One)
Current Address:____
____

Current Phone: ______________________________________

I understand that my medical records or the medical records of the patient for whom I am signing are covered by federal regulations and are protected under these regulations and cannot be disclosed without my written consent. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I may inspect the protected health information to be used or disclosed or refuse to sign this authorization. Rainbow Pediatrics may not condition my treatment on my provision of this authorization. I also understand that I may revoke this consent at any time except to the extent prior action has been taken on it. In any event this consent will expire on __________________________ or no longer than 90 days from the date the authorization is signed. A photocopy or facsimile of this authorization is as valid as the original.

Signature:____ Date: __________________________