after hours pediatrics

Authorization to Release Health Information

*Request for **AHP Records***

Please read thoroughly, incomplete authorizations will not be processed.

Form Submission Options: Email: ahpROI@ahpeds.com (preferred); Fax: 505-298-2985; Mail: 5904 Holly Ave NE, Albuquerque, NM 87113

To prevent delays in processing this request please complete all sections of the authorization.

Patient name:_____ Date of birth:_____

1

I authorize **After Hours Pediatrics** to **release** my health information **to**:

Name: _____
Organization/Persons Receiving the Information

Address:_____
Street City State Zip

Phone Number: (____)_____ Fax Number: (____)_____

Email/Secure File Exchange: _____

2

The purpose of the disclosure is:

☐ Continued patient care (if sending to another provider) ☐ Moving/Changing Doctor ☐ Personal request

☐ Social services/disability ☐ Attorney/legal ☐ Other:_____

3

Information to be disclosed:

☐ Transfer of Care Packet (Most common)

- Includes Problem List, Medication List, Allergy List, Growth charts, Immunization History, and three (3) most recent Wellness exams

☐ Laboratory Reports ☐ Billing or claims information ☐ Entire record of services (excludes records from other facilities)

☐ Other: _____

4

Your initials are required to release the following information:

___Contraception/Family Planning Services ___Sexually transmitted infections/diseases ___Behavior Health/Psychiatric Care

___Drug, Alcohol, or Substance Abuse Record ___AIDS/HIV Test Results/Treatment

For the release of information in this section, this form must be signed by the patient if the patient is 14 years old or older.

5

Information from (date) _____ to (date) _____ can be released.

6

Media Type: ◯ Electronic (CD/PDF) ◯ Paper (additional fee may apply)

Delivery Preference: ◯ MyAHP Portal ◯ Email (via Secure File Exchange) ◯ Pick-up ◯ Mailed (additional fee may apply)

7

This authorization will expire six (6) months from the signature date **OR** Alternate expiration date: _____

I understand that:

I have the right to revoke this authorization in writing at any time by providing proof of identity and requesting that it be revoked. Revocation will not apply to information that has already been released. I have a right to inspect or copy the information to be disclosed. Treatment or payment for treatment is not conditioned on the signing of this authorization. The recipient of information disclosed under this request is responsible for preventing any further disclosure that might violate federal privacy laws or regulations.

_____ Date:_____
Signature of patient or legal representative

_____
Printed name of legal representative

Signer of this document: ◯ Patient ◯ Parent ◯ Guardian ◯ Other: _____

Contact Phone Number: (____)_____

OFFICE USE ONLY

Staff receiving/reviewing form: _____ date: _____

Final delivery: ___Released in person ___Portal ___Pick-up arranged ___Secure File Exchange ___Other:_____

Staff releasing records: _____ date: _____

USPS Tracking #: _____

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after hours pediatrics

Authorization to Release Health Information

*Request for **Outside Records***

Patient name: _____

Date of birth: _____

Please read thoroughly, incomplete authorizations will not be processed. To prevent delays in processing this request please complete all sections of the authorization.

1

I authorize **After Hours Pediatrics** to **obtain** my health information **from**:

Name: _____ Phone Number: (____) _____
Organization Providing the Information

Address: _____
Street City State Zip

Fax Number: (____) _____ Email/Secure File Exchange: _____

2

Please send requested medical records to:

After Hours Pediatrics

1. Email/Secure File Exchange: **ahpROI@ahpeds.com** (preferred)
2. Fax: (505) 298-2985
3. Mail: 5904 Holly Avenue NE, Albuquerque, NM 87113

****Covered Entities without Secure Email Service****
Please call us to request a link for Secure File Drop Off
(ask to speak with a member of our Medical Records team)
Phone Number: (505) 298-2505

3

The purpose of the disclosure is:

☐ Moving/Changing Doctor ☐ Continued patient care ☐ Other: _____

4

Information to be disclosed:

☐ Transfer of Care Information
- Please include Problem List, Medication List, Allergy List, Growth charts, Immunization History, and three (3) most recent Wellness exams

☐ Immunization Records Only ☐ Laboratory Reports ☐ Specialist notes: _____
Indicate specialty

☐ Other: _____

5

☐ I authorize the release/peer-to-peer discussion of my **Behavior Health/Psychiatric Care**. _____Initials of patient or representative

For the release of information in this section, this form must be signed by the patient if the patient is 14 years old or older.

6

Information from (date) _____ to (date) _____ can be released.

7

This authorization will expire six (6) months from the signature date **OR** Alternate expiration date: _____

I understand that:

I have the right to revoke this authorization in writing at any time by providing proof of identity and requesting that it be revoked. Revocation will not apply to information that has already been released. I have a right to inspect or copy the information to be disclosed. Treatment or payment for treatment is not conditioned on the signing of this authorization. The recipient of information disclosed under this request is responsible for preventing any further disclosure that might violate federal privacy laws or regulations.

_____ Date: _____
Signature of patient or legal representative

_____
Printed name of legal representative

Signer of this document: ◯ Patient ◯ Parent ◯ Guardian ◯ Other: _____

Contact Phone Number: (____) _____

OFFICE USE ONLY

Staff receiving/reviewing form: _____ date: _____

Staff obtaining records: _____ date: _____

Request sent via: ___Fax ___Secure File Exchange ___Other: _____