# Small Steps Pediatrics, PC

**Shameza L. Boyd MD, FAAP**
**52 Medical Park Dr. E**
**Suite 201**
**Birmingham, AL 35235**

**Authorization for Release of Information**

**PATIENT INFORMATION**

Patient Name: ______________________________

Street Address: ______________________________

City/State/Zip: ______________________________

Phone: (        ) ____________________ Date of Birth: ____________________

**RELEASE OF INFORMATION**

1. This authorization applies to the following information:

______ ALL information, including diagnosis, treatment, hospitalization, discharge treatment/needs, and/or outpatient care for my/my child's condition, including psychological or psychiatric impairment, drug and/or alcohol abuse, or Acquired Immunodeficiency Syndrome (AIDS), or tests for or infection with Human Immunodeficiency Virus (HIV).

______ Only the following records or types of information:
Children aged 5 and above—immunization record, last EPSDT screening or check-up and last 3 years of progress notes.

______Other information as specified: ______________________________

______________________________

2. The information may be released by:

______________________________
(Organization/Agency releasing information)

______________________________
(Street Address)

______________________________
(City,State, Zip Code)

3. The information is to be released to by **mail** to:

**Small Steps Pediatrics, PC**
**52 Medical Park Dr. E, Suite 201**
**Birmingham, AL 35235**
**(205) 868-3486 (P)**
**(205) 868-3488 (F)**

I understand the information released will be limited to information necessary to fulfill the need or purpose for the disclosure. As a result of my signing this authorization, I understand an individual or organization that received this information may not be covered, and therefore the information no longer protected under the Health Insurance Portability and Accountability Act.

Signature: ______________________________ Date: ____________________