The solo pediatric practices of

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
WE ASK THAT YOU MAIL RECORDS IF NUMBER OF PAGES EXCEEDS 10

Patient Name: ______________________________ Date of Birth: ______________

Address: ____

City: ______________ State: _____ Zip: ______ Telephone: ______________

❖ **I authorize medical information to be released:** (Complete name & address required.)

To: ______________________ **From**: ______________________

______________________ ______________________

______________________ ______________________

❖ ***INITIAL ALL*** **items you authorize to be released:**

_____ Complete Record ***(All Info)***
_____ Medical History
_____ Billing Records
_____ Immunization Records
_____ Allergy List
_____ Drug/Alcohol Treatment
_____ Mental Health Info.
_____ Lab Results: ______________________
_____ X-ray & Imaging: ______________________
_____ Other: ______________________
_____ Genetic Testing
_____ HIV/AIDS Info.

❖ **Purpose of disclosure: (Check all that apply)**

__ Changing Physicians __ Moving __ Changing Insurance Other: ______________

❖ **This authorization is valid until** ____/____/____ (Specify a date up to one year from date of signing
MM DD YY

Governances of Disclosure

The information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of privacy of this information once it has been disclosed to another party.

You may revoke this authorization in writing at any time except to the extent that our offices have already acted on this authorization. To do so, submit a written request to your physician at the address above.

You may refuse to sign this authorization. Your refusal may not deny your treatment at our offices.

You may inspect or copy the information disclosed under this authorization for personal use. Your medical records may contain information that only a physician can interpret. To prevent any misinterpretation of this information you should contact your physician regarding any entries in question.

______________________ ______________________ ______________
Parent/Legal Guardian's Printed Name Parent/Legal Guardian's Signature Date