



# Pediatric Partners

## AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Failure to provide all information may invalidate this authorization)

Releasing Facility:	Send Records to:
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### INFORMATION TO BE RELEASED:

- IMMUNIZATION RECORD ONLY
- MEDICAL RECORDS - Date range: \_\_\_\_\_ to \_\_\_\_\_  ALL RECORDS
- TEST RESULTS; TYPE OF TEST \_\_\_\_\_ Date: \_\_\_\_\_  ALL TESTS
- MEDICATION LIST

### REASON RECORDS ARE TO BE DISCLOSED:

- CONTINUED CARE
- PERSONAL USE

This authorization will expire after request is fulfilled and shall not extend beyond 180 days from the date of signature.

(Date: \_\_\_\_\_) The recipient of the protected health information under the authorization will not re-disclose the information, except with a written authorization or as specifically required or permitted by law.

The above healthcare providers will not condition the provision of care or the receipt of benefits on the signing of the authorization.

Signing this form is voluntary. The patient or patient's representative has the right to revoke this authorization and the right to inspect/ or be given a copy of the material to be disclosed. (For details on disclosure of information and patient rights, see **HIPPA information and compliance policies** available for viewing at the office or on our website [pediatricpartners.net](http://pediatricpartners.net))

I have read these policies and voluntarily authorize and request the disclosure above. I authorize use of a copy (including facsimile) of this form for disclosure as described above.

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Identity Verified by :  Photo ID  Matching Signature