Pearl Pediatrics and Adolescent Medicine

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AUTHORIZATION FOR USE / RELEASE OF HEALTH INFORMATION

Patient Name:______________________________________

Date of Birth: ________________

Parents Name:___________________________

Phone Number: ___________________________

By signing this form, I authorize Pearl Pediatrics and Adolescent Medicine to use, release, disclose or obtain the protected information below:

Name and Address of person and/or Organization (Please mark one) *REQUIRED*

- ☐ From whom should be obtain.
- ☐ To whom information should be sent.

Doctor: ___________________________ Name of Practice:______________________________

Address: _______________________________City:______________Sate/Zip:________________

Phone #:__________________ Fax #:________________

Description of Health Information to be Disclosed

- ☐ Complete Medical Records (Please specify dates of service)
- ☐ Partial Medical Records (Please specify records below)

Information **Dates**

- ☐ Well Visits & Shot Records ____________
- ☐ Office Notes ____________
- ☐ Lab Results/ X-Rays ____________
- ☐ Other (Please specify and include date of service) ________________

Unless I request in writing otherwise, I unserstand that this authorization will expire on _______. If I do not enter an expiration date or event, this authorization will expire in 1 year from the date signed.

I understand that this information authorized to be released or obtain shall include, but not limited to infectious or contagious disease.
I understand that I have the right to revoke this authorization at any time. I understand that the if I revoke this authorization, I must do so on writing and present my writing revocation to Pearl Pediatrics and Adolescent Medicine. I understand that the revocation will not apply to any health information that has already been released in response to this authorization.
I understand that if my health information is disclosed to a party other than the health provider, health plan or healthcare clearinghouse subject to the federal privacy regulation, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.
I understand that federal and state laws allow a fee to be charged for the copying of patient records & I will be responsible for the payment of such fees.

____
Signature of Parent (or guardian)

Date:______________

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Relationship to patient