



Pediatric Partners

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Failure to provide all information may invalidate this authorization)

FACILITY RELEASING RECORDS: _____

PLEASE SEND RECORDS TO: _____

INFORMATION TO BE RELEASED:

- IMMUNIZATION RECORD ONLY
- ALL MEDICAL RECORDS
- TEST RESULTS; TYPE OF TEST _____
- 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*)

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: _____ Time: _____

Relationship to Patient: _____