Dekalb Pediatric Associates, P.C.

Authorization for Use or Disclosure of Protected Health Information

Patient Name_____**Date of Birth:**_____/_____/_____

_____

Address City State Zip

Cell Phone_____ Home Phone_____

☐ I Authorize _____

Address:_____

Phone:_____Fax:_____

To RELEASE my protected health Information to DEKALB PEDIATRIC ASSOCIATES, P.C. as indicated below:

☐ I Authorize **DEKALB PEDIATRIC ASSOCIATES, P.C.** to use or disclose my protected health information as indicated below to:

_____

Name of Entity to Receive this Information

_____

Address City State Zip

_____

Phone Number Fax Number

INFORMATION TO BE RELEASED:

- ☐ From & To Dates_____
- ☐ History and physical exam
- ☐ Office Notes
- ☐ X-ray reports
- ☐ Hospital Records / Discharge Summary
- ☐ Medication records
- ☐ HIV and All related Labs
- ☐ Other:_____

PURPOSE OF DISCLOSURE

- ☐ Changing Physicians
- ☐ Continuing Care
- ☐ At Patient Request
- ☐ Second Opinion
- ☐ Legal
- ☐ Insurance/Workers' Compensation
- ☐ School
- ☐ Other:_____

I understand that I may revoke this authorization at any time by notifying DEKALB PEDIATRIC ASSOCIATES, P.C. in writing. This authorization will cease to be effective on the date notified except to the extent that the Practice has acted in trust upon this authorization.

_____

Dekalb Pediatric Associates, P.C.

Signature of Patient or Legal Guardian / Printed Name Date

I understand that this authorization will expire on or before this date:_____