EASTERN PEDIATRICS, P.A.

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AUTHORIZATION TO USE / RELEASE / DISCLOSE HEALTH INFORMATION

Section A: (Must be completed for all authorizations)

I, _____, understand that Eastern Pediatrics is authorized by me to use, release, and/or disclose the Protected Health Information (PHI) as described below. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the Privacy regulations.

Patient's Name: _____ **Date of Birth:** _____

RELEASE FROM:

Name: _____

Address: _____

_____

RELEASE TO:

Name: _____

Address: _____

_____

I authorize the following information to be released to the above address: (check all that apply)

☑ Copies of medical records for the period: _____ to _____

☐ Copies of information described below for the period: _____ to _____

- ☐ History & Physical examination
- ☐ Reports from other physicians
- ☐ Lab, X-ray, etc. reports
- ☐ Other (please specify) _____

☐ The following information should ***not*** be released (please specify):

_____

Reason for Transfer/Disclosure: _____

If transferring for insurance reasons, please specify insurance company: _____

Section B: (Must be completed for all authorizations)

I understand that:

- I may revoke this authorization at any time by notifying the Practice's Privacy Officer in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively. I may request or copy the protected health information to be used or disclosed.
- This authorization will expire ten years from today's date unless otherwise specified.
- Eastern Pediatrics assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization.

Patient/Parent/Guardian Signature: _____ **Date:** _____