Professional Park Pediatrics
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Authorization to Disclose Protected Health Information

Patient Name: _____ Date of Birth: _____
(Last, First, Middle) (MM, DD, YYYY)

Home Address: _____

_____ Phone Number: _____

Person or Entity to Receive Information:
Name: _____

Address: _____

_____

Phone: _____ Fax: _____

Person or Entity to Disclose Information:
Name: _____

Address: _____

_____

Phone: _____ Fax: _____

Purpose Of Disclosure:
___ Changing PCP & Discontinuing Care at this Office
___ Moving & Transferring Records to New Physician
___ Personal Reasons
___ Attorney
___ Change of Insurance & Transferring Records to New Physician
___ Other (Please Specify): _____

Specific Information to be Disclosed:
___Complete Medical Record
___ Immunization Records
___ Other (Please Specify): _____

_____

I understand that once my or my child's records have been transferred to another local Primary Care Facility, Professional Park Pediatrics has released all care permanently.

I understand that information in my or my child's records may include information relating mental health or behavioral services and/or treatment for alcohol or drugs, and/or sexually transmitted infections, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). I agree to such release upon signing this form.

I understand that Professional Park Pediatrics is given 30 (thirty) days to process my request for access to my or my child's medical records. I further understand that my rights are limited to any information in my or my child's medical file as defined in Section 164.501 of the Code of Federal Regulations.

_____ _____

Parent/Guardian Signature (Patient if 18+) Date (MM/DD/YYYY)

_____

Parent/Guardian Name (Please Print0