



RECORDS RELEASE AUTHORIZATION (OUTGOING PATIENTS)

I AUTHORIZE REIS PEDIATRICS TO RELEASE PROTECTED HEALTH INFORMATION TO:

Name of Healthcare Provider: _____

Address: _____

Telephone Number: _____

Fax Number: _____

All Healthcare Information

Lab Report(s) Date(s) _____

Immunization Record Only

Consultation Note(s) Date(s) _____

For the following patients:

Child/children's name(s) and date(s) of birth: _____

Parent's name: _____

Address: _____

Phone number: _____

Reason for leaving Reis Pediatrics: _____

Signature: _____ Date: _____

This Authorization will expire 90 days after the date identified above. You can cancel this authorization at any time, but you must do so in writing. If you cancel it, the people authorized to use and disclose your protected health information may use the information collected prior to the date you revoked this authorization. Please send written revocation to the individual or department who you authorized to use your protected health information. Also, please be aware that once we disclose this information per your instructions, the information is subject to re-disclosure and may no longer be protected.

Office Use Only

Outstanding Patient Balance: _____

Outstanding Insurance Balance: _____

Date Payment Collected: _____

CA CC CK

Date Faxed: _____

