



Pediatric HealthCare Associates, P.A.
Mom Tested • Kid Approved

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date: _____

Patient Name: _____

Date of Birth: _____

Description of the specific information to be used or disclosed: (Please check one of the following):

____ All Information

Or Specific information like the following:

____ Pick up Patient Records

____ Cancel, reschedule make appointments for patient

____ Call to get Patient's results

____ Pick up patient's medicine/samples

Write names of people we can give out information to and the relationship to them. If you Do Not want us to release any information to anybody, just cross out the page.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the Authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA.

Patient Signature: _____ Date: _____

Patient Phone Number: _____

