



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO PEDIATRIC POD

PATIENT'S NAME _____ DATE OF BIRTH _____

I, the undersigned, authorize the release of or request access to the information specified below from the medical record(s) of the above named patient, which is called "Protected Health Information" under a federal health privacy law, as described below:

The Protected Health Information will be used for the following purposes:

Changing Physician ___ Insurance Application ___ Billing ___ Other: _____

Specific Information to be Used or Disclosed: Date of service(s) : ___ All ___ Specified Dates: _____

___ All Medical Records *** Please include Vaccine Records and Growth Charts ***

___ Vaccine Records ___ Growth Charts ___ Lab Reports ___ Radiology Reports ___ Specialist(s) Notes

___ Other _____

Persons or Class of Persons Authorized to Make the Use of Disclosure: PEDIATRIC POD

Above information released **FROM**

(Doctor, Hospital, Insurance Company, Self, etc.)

Phone Number

Address (Street, City, State, Zip Code)

Fax Number

- I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that I may revoke this authorization at any time by notifying PEDIATRIC POD in writing. However, if I chose to do so, I understand that my revocation will not affect any action taken by PEDIATRIC POD before receiving my revocation. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in the health plan, or eligibility for benefits.

Print Name of Patients Representative

Signature of Parent or Guardian

Relationship to Patient

Date

Office Representative Initials

Faxed Date:

PEDIATRIC POD
Aida Khanum MD MPH
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