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: ***(Check all that apply)***
Changing Physician:______Insurance Application:_______Billing:_________ Other:_________

Specific Information to be Used or Disclosed: ***(Check all that apply)***
_____All Medical Records: Please include Vaccine Records/Growth Charts

_____Vaccine Records____Growth Charts____Lab Reports____Radiology Reports
_____Specialist(s) Notes_________Other

Specified Dates: _______Date of service(s) :_________All:______

Persons/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: _____________________

PEDIATIC POD
Aida Khanum MD MPH
5410 Bellaire Blvd. Suite D, Bellaire, Texas 77401. Phone: 713-669-1900 Fax:713-669-1988