Growing Healthy Children

Growing Children Happy and Healthy

Authorization for Disclosure of Health Information

Patient Name:____

Date of Birth:____________________ Phone:____________________

Address:____

City:____________________ State:____________________ Zip: ____________

1. *I authorize the use or disclosure of the above named individual's health information as described below.*
2. *The following individuals are authorized to obtain information (please list names and phone numbers):*

Name	Relationship to patient	Phone #

3. The type and amount of information to be used or disclosed is as follows:

____ Complete health records

____ Physical exam

____ Immunization record

____ Other (please specify):________________________________

____ Lab/Imaging results

____ Consultation reports

____ Bills/Account Balances

4. The forms of contact that this information may be disclosed in is as follows:

____ Phone ____ Voicemail ____ Email ____ Fax

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assume treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

______________________________ ____________________

Signature of patient or legal representative Date