AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ **Date of Birth:** ____/____/____

Summerwood Pediatrics is authorized to release protected health information about the above named patient to the entities names below.

ENTITY TO RECEIVE INFORMATION Check each person/entity that you approve to receive information.	**DESCRIPTION OF INFORMATION TO BE RELEASED** Check each that can be given to the person/entity to the left of the same section.
PARENT/PATIENT CONTACT INFORMATION ☐ Voice Mail: (_____)_____ ☐ Email: _____ ☐ Work Fax: (_____)_____	☐ Results of Lab tests, Imaging ☐ Physical form, Notes, Letters, Immunizations ☐ Other: _____
☐ Parent (provide name/name's) _____P: (____)_____ _____P: (____)_____	☐ Financial ☐ Medical: Without restrictions ☐ Medical-Restrictions as follows: _____
☐ School (Year _____) (provide name) _____F: (____)_____ P: (____)_____ ☐ Daycare (provide name) _____F: (____) _____ P: (____)_____	☐ Notes/Letters ☐ Physical form/Immunizations ☐ Ongoing verbal exchange of information ☐ Other _____
☐ Other (provide name/name's) _____P: (____)_____ _____P: (____)_____	☐ Ongoing verbal exchange of information ☐ Medical: Without restrictions ☐ Medical-Restrictions as follows: _____

PATIENT INFORMATION:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I acknowledge and am aware of the security risks associated with unsecure transmission of my personal health information. By signing this form, I accept the risks and agree to have my personal health information sent by the method indicated above.

I understand that information used or disclosed as a result of this authorization maybe be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

THIS AUTHORIZATION IS ONLY IN EFFECT FOR ONE YEAR FROM THE DATE OF SIGNATURE.

_____ **Date:** ____/____/____

Patient/Parent Signature