AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

I _____(print patient's name)

voluntarily consent to authorize _____

_____ (print name) to disclose my Health Information to:

KinderHealth, LLC, 10 W. West Street, Baltimore, MD 21230
Phone: 410-697-5357 **Fax:** 410-457-9626

Information to be disclosed: I authorize the release of the following health information: (check the applicable option below):

__ Complete Record
__ Immunization Sheet
__ Specific Notes_____
__ Labs

Term: I understand that this Authorization will remain in effect:

- ❑ From the date of this Authorization until the _____ day of _____, 20_____.
- ❑ Until the Provider fulfills this request.
- ❑ Until the following event occurs:_____

I understand that this authorization gives my/parent or legal guardian permission to release any Protected Health Information(PHI) that is contained in the Medical Record unless they specifically indicate "NO" next to the categories below:

___Substance Abuse Information
___Psychiatric/Mental Health Information
___HIV Information

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at KinderHealth, LLC. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to KinderHealth, LLC. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Patient: _____ Phone_____

Date of Birth: _____ Signature_____

If Individual is unable to sign this Authorization, please complete the information below:

_____	_____	_____	_____
Name of Guardian/ Representative	Legal Relationship	Date	Witness