AUTHORIZATION FOR USE/DISCLOSURE
OF HEALTH INFORMATION

Patient Name:
Patient DOB:
Patient Address/Phone Number:

I ____voluntarily consent to authorize

KinderHealth, LLC to disclose the Health Information of the above patient to:

____

____

(Name, Address, Phone and Fax Number of Recipient)

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
__ Other (Please specify) ____

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 the permission to release any Protected Health Information (PHI) that is contained in the Medical Record unless I 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.

Signature of Parent/Guardian or Patient (if 18 years or older): ____________________________________

Printed Name/Relationship to patient: ____

Date: _________________________