

Helping Hands Pediatrics, Inc.

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AUTHORIZATION FOR RELEASE OF INFORMATION

I HEARBY AUTHORIZE THE USE OR DISCLOSURE OF MY INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION AS DESCRIBED BELOW. I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY. I UNDERSTAND THAT IF THE ORGANIZATION AUTHORIZED TO RECEIVE THE INFORMATION IS NOT A HEALTH PLAN OR HEALTH CARE PROVIDER, THE RELEASED INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS.

PATIENT NAME: _____ DATE OF BIRTH: _____

PERSONS / ORGANIZATIONS
PROVIDING THE INFORMATION

PERSONS / ORANIZATIONS
RECEIVING THE INFORMATION

SPECIFIC DESCRIPTION OF INFORMATION TO BE RELEASED: _____

REASON FOR MEDICAL INFORMATION TO BE RELEASED: _____

THE PATIENT OR THE PATIENT'S REPRESENTATIVE MUST READ AND SIGN THE FOLLOWING:

1. I UNDERSTAND THAT THIS AUTHORIZATION WILL EXPIRE ON ___/___/___ INITIAL _____
2. I MAY REVOKE THIS AUTHORIZATION BY NOTIFYING THE INFORMATION PROVIDER IN WRITING BEFORE ANY ACTION IS TAKEN TO RELEASE INFROMATION. ___/___/___

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE: _____

PRINTED NAME OF PATIENTS'S REPRESENTATIVE: _____ DATE: _____

RELATIONSHIP TO PATIENT: _____

PHONE: _____

PLEASE FAX ALL RECORDS TO (724) 346-3018

Inner office use only

DATE FAXED: _____ INITIALS: _____