BAYSIDE PEDIATRICS

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Date faxed: ____________

Employee initials: ________

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

By signing this form, I understand that I am authorizing Bayside Pediatrics to use and/or disclose my Protected Health Information (PHI), as described below to the following person(s) and/or organization(s). I understand this authorization may be revoked in writing at any time, except when action has been taken based upon the authorization. This authorization complies with the Health Insurance Portability and Accountability (HIPPA). Bayside Pediatrics, its employees, directors, and medical staff members are released from any liability for disclosure of my PHI to the extent authorized. Unless otherwise revoked, this authorization will expire 90 days from the date signed.

I HEREBY AUTHORIZE :

___ Name of doctor's office/clinic, address, telephone & fax #:

____

____

TO BE RELEASED TO:

___ Name of doctor's office/clinic, address, telephone & fax #:

____

____

RECORDS TO BE RELEASED: (Please fax, Do Not Mail or Send CD's)

Check all that apply

___ All Medical Records-The last 3 office visits including the most recent well visit, lab results, growth charts, x-rays and immunization records.

___ Immunization records ___ Mental Health Evaluation & Treatment

___ Labs/Radiology reports including HIV/AIDS, Drug and alcohol records

___ Other information (Please specify) ______________________________

___ Hospital Records - Only send most recent discharge summary including any labs & x-rays for that visit.

Date: ____________________ **Phone #:** ____________________________

Patient Name: ___________________________**Date of Birth:**____________

Parent/Legal Guardian: (Print) ______________________________________

Signature: ____

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