



**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

<b>PATIENT NAME (Last, First, MI)</b>			<b>Date of Birth</b>
Address	City	State	Zip
Best Contact Phone		Other Phone	
PARENT/GUARDIAN NAME			Relationship to Patient
My signature below affirms that I am the legal guardian of the above listed patient, having full authority to request, receive and transfer Medical Health Records. I agree to take full responsibility for such records.			

**I hereby Authorize Intown Pediatric & Adolescent Medicine, PC to:**

**Release my child's protected health information to:**

\_\_\_\_\_  
Doctor

\_\_\_\_\_  
Address or Practice

\_\_\_\_\_  
Fax Number

\_\_\_\_\_  
Office Number

**Request my child's protected health information from:**

\_\_\_\_\_  
Doctor

\_\_\_\_\_  
Address or Practice

\_\_\_\_\_  
Fax Number

\_\_\_\_\_  
Office Number

**INFORMATION TO BE RELEASED:**

- From & To Dates \_\_\_\_\_
- History and physical exam
- Office notes
- X-ray reports
- Lab reports
- Hospital records
- Medication records
- Immunization records
- Other: \_\_\_\_\_

**PURPOSE OF DISCLOSURE:**

- Changing physicians
- Continuing care
- At patient request
- Second opinion
- Legal
- Insurance/Workers' Compensation
- School
- Other: \_\_\_\_\_

This authorization expires 90 days (ninety) from: \_\_\_\_\_  
**Expiration Date or Defined Event**

**I understand that I may revoke this authorization at any time by notifying Intown Pediatric & Adolescent Medicine, P.C. in writing. This authorization will cease to be effective on the date notified except to the extent that the practice has acted in trust upon this authorization.**

\_\_\_\_\_  
**Signature of Parent or Legal Guardian**

\_\_\_\_\_  
**Date**