AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME (*Last, First, MI*)				**Date of Birth**
Address	City		State	Zip
Best Contact Phone	Email Address			
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:	**PURPOSE OF DISCLOSURE:**
☐ From & To Dates ____________	☐ Changing physicians
☐ History and physical exam	☐ Continuing care
☐ Office notes	☐ At patient request
☐ X-ray reports	☐ Second opinion
☐ Lab reports	☐ Legal
☐ Hospital records	☐ Insurance/Workers' Compensation
☐ Medication records	☐ School
☐ Immunization records	☐ Other: ____________
☐ Other: ____________	

This authorization expires 90 days (ninety) from: ______________________________

Expiration Date or Defined Event

☐ ***By checking this box, I authorize records to be sent via unencrypted email to my email address on file. I accept the risks of sending and receiving Protected Health Information (PHI) via unencrypted email and I hold harmless Intown Pediatrics from any and all liability.***

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**