AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FROM:
ACCLAIM PEDIATRICS

PATIENT'S NAME_____ **DATE OF BIRTH :**_____
(Please Print Name)

I, the undersigned, authorize the release of or request access to the information specified below from the medical record(s) of the above named patient, which is called "Protected Health Information" under a federal health privacy law, as described below:

The Protected Health Information will be used for the following purposes:
___Continuation of Care ___Insurance Application ___Billing Records
___History & Physical ___Other (description) _____

Specific Description of the Information to be Used or Disclosed (including the date of service(s):
___All Medical Records ___Newborn Records (Name of Hospital) _____
___Shot Records Only ___Other _____

Persons or Class of Persons Authorized to Make the Use of Disclosure: Acclaim Pediatrics

The above information may be released (**TO**) _____ (specify name or title of individual or the name of the organization to which records are to be released and the appropriate address):

(Doctor, Hospital, Insurance Company, Self, etc.) Phone Number

Address (Street, City, State, Zip Code)

I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.
I understand that I may revoke this authorization at any time by notifying Acclaim Pediatrics in writing. However, if I chose to do so, I understand that my revocation will not affect any action taken by Acclaim Pediatrics before receiving my revocation. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in the health plan, or eligibility for benefits. This authorization will expire in one year from date signed.

Print Name of Patients Representative

_____ _____ _____
Signature of Parent or Guardian Relationship to Patient Date

Office Representative Initials _____ Completed Date: _____