Pediatric Care, Inc.

Authorization to Disclose Protected Health Information to Parents or Guardian

I understand that it is the policy of Pediatric Care Inc. to protect the privacy of all its patients and to follow all state and federal patient privacy laws. I hereby authorize Pediatric Care Inc. to disclose medical information about myself to my parent(s) or guardian(s).

I understand that I have the right to refuse to sign this Authorization to release my Protected Health Information.

I understand that I may revoke this Authorization at any time after I have signed it by providing a written statement that I wish to revoke this Authorization. (Please send all written revocations of Authorization to: Pediatric Care, Inc. Attn: Medical Records, 8250 Winton Road Suite 103, Cincinnati, Ohio 45231.) The revocation of my Authorization will be effective immediately upon Pediatric Care Inc's receipt of the written revocation and my Protected Health Information can no longer be used/disclosed pursuant to this Authorization except to the extent of Pediatric Care Inc. has already taken action in reliance upon the validity of the Authorization.

I understand that if my Protected Health Information is disclosed, then this information may be subject to re-disclosure by the recipient and may no longer be protected by the federal privacy laws.

This Authorization shall remain in effect for as long as I am a patient at Pediatric Care Inc. unless I choose to revoke it earlier in writing.

_____ _____

Patient's Printed Name Date of Birth

_____ _____

Patient's Signature Date

Patient's Cell# _____