Patient's Name:_____ DOB:_____

Patient's Cell#_____

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 patients and to follow all state and federal patient privacy laws.

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

I authorize Pediatric Care, Inc. to disclose medical and billing information about myself to

X_____ _____
Name of authorized person Relationship

X_____ _____
Patient's Signature Date

I **DO NOT** authorize Pediatric Care, Inc. to disclose any Protected Health Information to anyone.

X_____ _____
Patient's Signature Date

Authorization is in effect for as long as I am a patient at Pediatric Care, Inc. unless I choose to Revoke it earlier in writing. _____initials

I understand I may revoke this authorization at any time by submitting a written statement to Pediatric Care, Inc. _____initials