AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO SPROUT PEDIATRICS

PATIENT'S NAME_____ DATE OF BIRTH_____

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:
___Changing Physicians ___Insurance Application ___Billing ___Other: _____

Specific Information to be Used or Disclosed: Date of service(s) : ____All ____ Specified Dates: _____
___ All Medical Records *** Please include Vaccine Records and Growth Charts ***
___Vaccine Records ___ Growth Charts ___ Lab Reports ___ Radiology Reports ___ Specialist(s) Notes
___ Other _____

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

Above information released **FROM**

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

Address (Street, City, State, Zip Code) Fax Number

- **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 Sprout Pediatrics in writing. However, if I chose to do so, I understand that my revocation will not affect any action taken by Sprout 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.**

Print Name of Patients Representative

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

Office Representative Initials _____ Faxed Date: _____

SPROUT PEDIATRICS
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