Authorization for Disclosure of Protected Health Information

This completed form authorizes a third party to disclose a patient's protected health information to Little Star Pediatric Urgent Care.

Patient Information

Patient's Name: _____

Patient's DOB: _____ DOS: _____ Phone: _____

Reports to be Disclosed

Please indicate those reports that you would like to be disclosed.

All Information	_____	Growth Chart	_____
Consultation Reports	_____	Operative Reports	_____
Progress Notes	_____	Billing Claims Forms	_____
Radiology Reports	_____	Itemized Statement of Charges	_____
Laboratory Reports	_____	History and Physical Exam	_____
Pathology Reports	_____	Other:	_____
Immunization Record	_____	_____	
		_____	

Records Released From

Name _____ Phone _____

Mailing Address _____ Fax _____

City, State, ZIP _____

Records Released To

Name _____ Phone _____

Mailing Address _____ Fax _____

City, State, ZIP _____

Authorization

I authorize the third party named in the above section to disclose the protected health information about myself (or the patient) as described above. I understand

- This authorization expires 180 days from the date of my signature unless I specify otherwise (expiration _____).
- I may revoke this authorization at any time by notifying Little Star Pediatric Urgent Care in writing. If I revoke the authorization, I understand that it will have no effect on actions Little Star Pediatric Urgent Care took in good faith before receiving the revocation.
- The information released may contain information related to AIDS or HIV infection; drug or alcohol abuse; mental or behavioral health or psychiatric care, except for psychotherapy notes.
- Little Star Pediatric Urgent Care may not condition treatment or payment on my completion of this form.
- Little Star Pediatric Urgent Care reserves the right to verify my identity or guardianship.

Signature _____ Date _____

Printed Name _____

Relationship to Patient _____