HERE WE GROW
PEDIATRICS

AUTHORIZATION FOR DISCLOSURE, USE, OR RECEIPT OF PROTECTED HEALTH INFORMATION
****SEND RECORDS SEPARATELY****

Patients First and Last Name: _____ DOB:_____
Sibling #1:_____ DOB:_____ Sibling #2:_____DOB:_____
Sibling #3:_____ DOB:_____ Sibling #4:_____DOB:_____
Address: _____ City:_____ State:_____
Zip Code:_____ Phone number: _____

I authorize _____(facility you are requesting from name & phone number) to disclose/receive the following protected health information about me/my children (in any form including verbal, written and electronic) for the time period of _____ to _____.

Check all that apply:

☐ Physician/Medication Orders ☐ Lab/X-Ray Reports HIV/AIDS Information ☐ Nursing Notes
☐ Physician Progress Notes ☐ DMR/ CD&E Reports ☐ Counseling Notes ARD/IEP ☐ Psychiatric Evaluation
☐ Treatment Plan/Treatment Reviews ☐ Discharge Summary ☐ Immunization Record ☐ Assessments:
Psychological, Nursing, Speech-Language, OT/PT, Social, Educational, Vision/Hearing ☐ Other, specify and include dates:

_____.

The facility's designated staff may disclose to/receive from the following individual, organization or facility:
Name: _____ Fax #: (___)_____ Phone#: (___)_____
This disclosure/use is for the following purpose(s): ☐ transferring care to new primary care physician
☐ personal use ☐ school ☐ legal purposes ☐ disability determination ☐ employment ☐ billing/insurance
Other, state:_____.

Note: If you are authorizing disclosure of information, then, except for information related to alcohol or drug abuse treatment, the potential exists for the information described in this authorization to be re-disclosed by the recipient. If the information is re-disclosed, then it is no longer protected by medical privacy laws.

Note: If you are signing as a parent/guardian/managing conservator of a minor or as a guardian of the person of an adult, the information disclosed/used/received may contain references about you and your family. You have the right to revoke this authorization. To revoke this authorization, you must deliver a written statement, signed by you, to the facility where you gave your authorization (identified above), which provides the date and purpose of this authorization and your intent to revoke it. Your revocation will be effective the date it is received by the facility, except to the extent that the facility has already relied upon your authorization to use or disclose your health information as described in the Notice of Privacy Practices.

Unless this authorization is revoked earlier it will expire 90 days from the date signed by the consumer or legally authorized individual, or as otherwise specified by date, event or condition of expiration: _____.

_____ _____
Signature of Patient/Legal Guardian Printed Name of Patient/Legal Guardian

_____ _____
Relationship to Patient Date Signed

Email: admin@hwgpediatrics.sprucecare.com **fax#: 210-899-1006 ph#: 210-465-1800**