AVON PEDIATRICS

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this form, I authorize *Avon Pediatrics* to disclose certain protected health information (PHI) about my child to the party or parties listed below.

This authorization permits *Avon Pediatrics* to disclose the following individually identifiable health information:

- ☐ Immunization Records
- ☐ Health Forms
- ☐ Sports Forms
- ☐ Medication Forms
- ☐ Other: (Must be specific) _____

Release the above information to the following person or entity to receive the information ***(include the fax number):***

_____

_____

_____

_____

This authorization will expire 60 days from the date of the signature below*. *(Indiana State Law IC 16-39—1(e) states an authorization is valid for 60 days after the date the request is made.)

When the information is disclosed according to this authorization, it may be re-disclosed by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except to the extent that *Avon Pediatrics* has already acted in reliance upon this authorization.

Patient's Name: _____ **Date of Birth:** _____

Address of Patient: _____

Signature of Parent or Legal Guardian: _____

Printed Name of Parent or Legal Guardian: _____

Date: _____