AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

I. **Patient's Name** _____ **DOB** _____ **Phone Number** _____

II. Please check one and provide the requested information:

☐ I hereby authorize All Star Pediatrics and Sports Medicine, PC and any of its Medical Providers to disclose my Protected Health Information to the following organization(s) and/or person(s):

Name: _____
Address: _____
Phone Number: _____ Fax Number: _____

☐ I hereby authorize_____ to disclose my Protected
(Primary Care Physician or other Health Care Provider)
Health Information to All Star Pediatrics and Sports Medicine and any Pediatric Center health care provider.

III. I authorize the following information to be disclosed:

Please check one and provide the requested information:
_____ Complete Medical Record, including records from other providers and immunizations
_____ Complete Medical Record, not including records from other providers
_____ GYN (Pap, Pelvic, Lab)
_____ Lab
_____ X-ray
_____ Other or Relating to Particular Problem_____

IV. Purpose of the Requested Disclosure: Please check one and provide the requested information.

☐ At the request of the patient.
(Patient.s initials)_____

☐ Other _____
(State specific purpose of requested disclosure)

I understand that I have a right to revoke this authorization at any time. My revocation must be in writing in a letter provided to The All Star Pediatrics and Sports Medicine, PC or other health care provider identified in Section II above, as applicable. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my Protected Health Information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that All Star Pediatrics and Sports Medicine, PC may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I further understand that if the persons(s) or organization(s) authorized to receive the information is not a health plan or health care provider, the released information may be re-disclosed and would no longer be protected by federal privacy regulations. I agree that a copy of this release or fax of this release shall be as valid as this original release. If I authorize All Star Pediatrics and Sports Medicine, PC to fax the information, I realize there are inherent risks in faxing Protected Health Information. **I understand a fee will be charged to cover the costs of copying**, including the cost of supplies and labor of copying and mailing Protected Health Information released to anyone other than another health care provider. I understand I will get a copy of this form after I sign it.

_____

Signature **Print** **Date**