Next Generation
PEDIATRICS

Authorization for Disclosure of Protected Health Information (PHI)

_____ _____ _____
Patient Full Name | Date of Birth | Today's Date

_____ _____
Patient's Address | Patient's Phone

The information is to be disclosed by:	**And is to be provided to:**
Name of facility	Name of Person / Facility
Address	Address
Phone Fax	Phone Fax

This authorization includes the release of the following records (Please check all that apply) for the following date or time span:

Date: _____ or specified date range _____ to _____
Day/ Month/ Year | Day/ Month/ Year

	Bills		Nurse's Notes
	Claims		Operative Reports
	EKG/Catheterization Reports		Physician Orders
	Emergency Room Records		Progress Notes
	Hospital Discharge Summary		Radiology Films/Imaging
	History and Physical		Radiology Reports
	Laboratory Reports		ANY AND ALL RECORDS

I understand that the medical records to be accessed may contain medical information pertaining to psychiatric, drug and/or alcohol, HIV/AIDS diagnosis and treatment. This authorization will expire one (1)year after the date of my signature. I confirm that I understand that I am free to revoke this authorization at any time by submitting a written request to the entity/provider disclosing the PHI. Any uses. or disclosure of my PHI prior to receipt of the revocation cannot be reversed and will not be covered by the revocation.

_____ _____
Printed Name | Signature of Person Granting PHI Disclosure