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Authorization for Disclosure of Health Information

Patient Name: ____ DOB: ______________________

Patient Name: ____ DOB: ______________________

Patient Name: ____ DOB: ______________________

I. Practice Name authorized to disclose Information (records from):

II. Individual or Organization authorized to receive information (records to):

KENT PEDIATRICS

III. Description of the information that may be disclosed:

_____________ Entire medical records

_____________ Medical records for the period of ______________ through _______________

_____________ Specific portion/section of the medical records as described below:

____

IV. Reason for disclosure/transfer of Health Records:

Acknowledgement:

- I understand that I have the right to know who my health information is being disclosed to.
- I understand that I have the right to know specifically what information is being disclosed.
- I understand that I have the right to know what my medical information is being used for.
- I understand that unless provided by law, I will be responsible for the charges associated with the disclosure of my health information. (For Kent Pediatrics, LLC, please refer to fee schedule on financial policy)
- I understand that I may revoke this authorization (except if the disclosure was already taken with this written authorization) at any time by notifying the office of **KENT PEDIATRICS** in writing.
- I understand that I have a right to receive a copy of this form.
- I understand that my refusal to sign this form will not affect my treatment.
- I understand that if the authorized individual or organization is not a health care provider or organization covered by federal privacy regulations, the information described herein may be re-disclosed without consent.

____ ________________________________

Patient / Legal Guardian Signature | Date of Request

____ ________________________________

Printed Name of Patient/ Legal Guardian | Relationship to Patient