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Authorization for Disclosure of Health Information

Patient Name: ____ DOB: ______________________

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

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

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 the following statement)

- This authorization will expire 90 days from the date of my signature.
- I may revoke this 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 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.
- I have the right to know who my health information is being disclosed to.
- I have the right to know specifically what information is being disclosed.
- I have the right to know what my medical information is being used for.
- Other than prohibited 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 the financial policy)

____ __________________________________

Patient / Legal Guardian Signature Date of Request

____ __________________________________

Printed Name of Patient/ Legal Guardian Relationship to Patient