ABC PEDIATRICS
ADOLESCENTS · BABIES · CHILDREN
702 WAKE AVE
EL CENTRO, CA 92243
760-352-7216
760-352-1028-FAX

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Date:_____

Patient Name:_____

Date Of Birth:_____

Relationship to patient(If signed by legal representative):_____

Phone Number:_____

Signature of patient or legal representative:_____

IMPORTANT INFORMATION REGARDING RIGHTS

Voluntary: I understand that the authorization and disclosure of the information is voluntary. I do not need to sign this form to ensure healthcare. Initials:_____

Rights to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that if i revoke this authorization, I must do so in writing and present my written revocation to Abc Pediatrics. The revocation will take effect upon receipt. I understand that the revocation will not apply to information that has already been released in response to this authorization. Initials:_____

Right to Inspect: I understand that I may inspect or obtain a copy of the information to be used or disclosed as provided in CFR 164.524 and that I have the right to a copy of this form. Initals:_____

Re-Disclosure: I understand that any disclosure of information carried with it the potential for an unauthorized re-disclosures and the information may not be protected by federal confidentialty rules. Initials:_____

Questions: If I have any questions or concerns about the disclosure of my child's health information, I can contact Abc Pediatrics Office Staff. Initials:_____

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AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO ADOLESCENT, BABIES & CHILDREN PEDIATRIC MEDICAL GROUP TO OBTAIN ALL MEDICAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.)

FOR (Patient Name) _____ D.O.B_____.

THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

_____ _____

PARENT / AUTHORIZED REPRESENTATIVE SIGNATURE DATE

HOME ADDRESS_____

HOME PHONE (_____)_____

WORK PHONE (_____)_____