Pinecone Pediatrics
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Authorization to Release Medical Records/Use Personal Health Information

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

Patient/Guardian Phone Number: _____

Purpose of Disclosure: □ Healthcare □ Transfer of Care □ Personal □ Other: _____

To Include: □ All Records □ Immunization Records □ Other: _____

I authorize Pinecone Pediatrics to release information to:	**OR**	I authorize Pinecone Pediatrics to obtain information from:
_____		_____
_____		_____
_____		_____
Phone: _____		Phone: _____
FAX: _____		FAX: _____

I understand that:

- Authorizing the disclosure of this health information is voluntary. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.
- I may cancel this authorization at any time by submitting a written request to the Privacy Officer, except where disclosure has already been made in reliance on my prior authorization. I understand that the revocation will not apply to any information that has already been released in response to this authorization.

Signature of Patient's Parent/Legal Guardian: _____

Relationship to Patient: _____ Date: _____