AUTHORIZATON FOR RELEASE OF INFORMATION

I authorize Einstein Pediatrics to use and/or disclose my child's/children's protected health information (PHI) to:

____

____

____

The information to be included for use and/or disclosure:
(Check one)

______ Medical record

______ Portions of the medical record as listed below
(specify date of service, type of service etc.)

____

The information will be used or disclosed for the following purpose:
(Check one)
______ Transfer medical record to another physician
______ At the request of the individual (if no purpose is stated)
______ Other (please specify) _______________________________________

This authorization will expire on ___________________________.
(Expiration date or Defined Event)
Ex. Upon completion of request.

I do not have to sign this authorization in order to receive treatment from Einstein Pediatrics. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer.

________________________________ ___________________________
Patient's Name | Date of Birth

________________________________ ___________________________
Signature of Parent/Legal Guardian/ Patient (if 18 or older) | Relationship to Patient

________________________________ ____________________________
Print name of Parent/Legal Guardian/ Patient (if 18 or older) | Date

PARENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION