PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize

_____

to disclose certain protected health information (PHI) about me to **Jeffersonville Pediatrics, 207 Sparks Ave., Ste. 403, Jeffersonville, IN 47130**.

(mark only one box)

- ❑ Entire medical record (**INCLUDING** Communicable Diseases and Drug and Alcohol treatment records)
- ❑ Entire medical record (**EXCLUDING** Communicable Diseases and Drug and Alcohol treatment records)
- ❑ Specific information:

Such as date(s) of service, level of detail to be released, origin of information, etc.:

_____

_____

Purpose of release: _____

This authorization will expire on _____.

(Expiration Date or Defined Event. **Valid for no more than 60 sixty days of receipt**.)

I have the right to revoke this authorization in writing except to the extent that action has been taken thereon.

Signed by: _____ _____ _____

Signature of Patient or Legal Guardian | Date | Relationship to Patient

_____ _____

Patient's Name | Date of Birth

_____

Patient's Address