PL Pediatrics

HIPAA NOTICE OF PRIVACY PRACTICE

Authorization to Release Patient Information

I, ______________________________ hereby authorize Dr. Mancini of PL Pediatrics, and/or their representatives to release any and all information pertaining to my heath care, results, procedures, billing, and/or accounting information to the following person(s) or agencies:

☐ **Myself** ☐ NO ONE

☐ Spouse: ______________________________
(Please PRINT name clearly)

☐ Mother: ______________________________
(Please PRINT name clearly)

☐ Father: ______________________________
(Please PRINT name clearly)

☐ Other: ______________________________ ______________________________
(Please PRINT name clearly) (Relationship to Patient)

☐ Other: ______________________________ ______________________________
(Please PRINT name clearly) (Relationship to Patient)

If you are the parent or guardian of a minor child you MUST put <u>your name AND any other authorized adults</u> on this form otherwise the child's information cannot be release to anyone without a signed release form.

I further authorize the providers and their representative(s) to release results of my medical exams in one or more of the following ways:

May call me (Patient) At this number: ______________________________
Phone number

May leave message on Voice mail At this number: ______________________________
Phone number

I understand that this office will release any information to those persons who I have determined may receive this information without separate consent. I also understand that this relates to all medical and billing/account information. **THIS WILL BE ACTIVELY ENFORCED**. If you wish to change the status of this form, you must do so in writing.

Patient Name: ______________________________ ______________
(PLEASE PRINT CLEARLY) Date

Signature: ______________________________ ______________
(PATIENT'S SIGNATURE) Date

Responsible Party Signature: ______________________________ ______________
(IF PATIENT IS A MINOR OR UNABLE TO SIGN) Date