Lossio Pediatrics, PLLC

RELEASE OF INFORMATION CONSENT

At times we receive requests by our patients and their family members regarding the patient's health status and other health management information (lab results, tests results, medication refills or changes, etc.)

To protect your patient confidentiality, we ask your permission to release this information to individuals you specify below. If you are unavailable or become incapacitated, which individuals do you approve our release of information to?

Please take time to fill out this form with the requested information. If an individual you have indicated requests information about you or for you, we will ask their address and phone number to be sure they are the one you designated. If you do not have all the information with you, please take this form home with you for completion and return it to us at your convenience.

NAME(S) OF PERSON(S) YOU AUTHORIZE US TO RELEASE INFORMATION TO:

Name	Relationship
Address	Phone Date of birth
Name	Relationship
Address	Phone Date of birth
Name	Relationship
Address	Phone Date of birth

I, _____ give _____ permission to release medical information (health status report, lab or test results, medication refill or medication changes) regarding my treatment and ongoing health care needs to the persons(s) I have indicated above.

Witness Signature	Patient Signature
Date	Date

Providers will share patient information with other providers who are involved in the patient's care, as appropriate. The data sharing may be through written medical information or through electronic sharing of information.