Patient Authorization of Use and Disclosure of Protected Health Information

The information on this form is used to facilitate our communication to you as we strive to provide excellent service. The provision of this information is optional.

Patient Information:

Last Name	First Name	Middle Name	Date of Birth

Authorization:

I, _____ (printed name of parent/guardian/adult patient), authorize Heart and Soul Pediatrics to contact me at the phone number on file (including leaving a voice message) regarding appointments or other matters pertaining to me or my child's care.

I authorization Heart and Soul Pediatrics to disclose Protected Health Information to the following persons:

Parent: _____

Parent: _____

Guardian: _____

Other: _____

Information to be disclosed:

- ☐ All Medical Information
- ☐ Lab Results
- ☐ All Billing/Account Information

Signature of Parent/Guardian/Adult Patient	Date