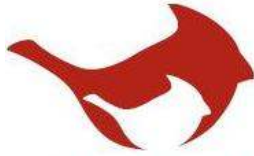

Cardinal Pediatrics, PLLC

Patient Authorization to Release Protected Health Information to Third Parties

Patient Name: ______________________________________Date of Birth: _______________

Authorization: I authorize Cardinal Pediatrics, PLLC to (1) disclose the above listed patient's PHI and (2) treat the above listed patient and disclose PHI when brought to the office by:

- Please include the Full Name of any family member (mother/father, grandparents, step-parents, etc) or Group organization (school, daycare) that may request access to the patients' medical records.

Name	Relationship	Phone Number*
__________________________	________________________	_______________________
__________________________	________________________	_______________________
__________________________	________________________	_______________________
__________________________	________________________	_______________________
__________________________	________________________	_______________________
__________________________	________________________	_______________________
__________________________	________________________	_______________________

*Phone number will be used to verify person's identity when calling office for PHI requests

Scope of Authority: I authorize Cardinal Pediatrics, PLLC to disclose the above listed patient's PHI as follows (check only one):

☐ All PHI that the above named entities may request. If applicable, this information may include information pertaining to chronic disease, behavior health conditions, communicable disease, including HIV/AIDS, and/or genetic information.

______ Also include any alcohol and substance abuse records, if applicable (indicate by initialing)

☐ Disclose ONLY the following PHI to the above name entity:

____
____

I understand that I may revoke this consent at any time, in writing, except where information has already been released. This authorization is valid until the patient reaches 18 years of age.

Signature: ____ Date: _________________
(Parent or Legal Guardian if minor child)

Printed Name: ____________________________________ Relationship:_________________
(Parent or Legal Guardian if minor child)