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 **Clark Pediatrics (formerly Jeffersonville Pediatrics), 207 Sparks Ave., Ste. 403, Jeffersonville, IN 47130**.

(mark only one)

__ 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.:

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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

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Patient's Address