**Authorization to release protected health information**
**To: SGH Pediatrics**

Patient Name: _____ Date: _____

I, the undersigned, authorize the release of or request access to the information specified below from the medical record(s) of the above named patient(s), which is called "Protected Health Information" under a federal health privacy law, as described below:

**The Protected Health Information will be used for the following purposes:**
**____** Continuation of care ____ Insurance Application _____ billing records
____ History & Physical ____ Transfer of Care ____ Other (description) _____

**Specific Description of the Information to be used or disclosed (including service date(s):**
**____**All Medical records ____Newborn Records (Hospital Name) _____
_____ Shot record only _____Other _____

**Persons or Class of Persons Authorized to Make the Use of Disclosure:** SGH Pediatrics

The above information may be released (FROM) _____
Specify Name of title of individual or the name of the organization from which records are to be released and the appropriate address.

_____
Doctor, Hospital, Insurance Company, Self, etc. Phone Number

_____
Address (Street, City, State, Zip Code)

**I understand that if the person or entity that receives this information is not a health plan or healthcare provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.**
**I understand that I may revoke this authorization at any time by notifying SGH pediatrics in writing. However, if I chose to do so, I understand that my revocation will not affect any action taken by SGH Pediatrics before receiving my revocation. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in the health plan, or eligibility for benefits.**

Parent/Guardian Signature Relationship to patient Date

Office Representative Initials: _____ Date Completed: _____

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