Carson Medical Group

PEDIATRIC

Consent to Disclose Protected Health Information

Patient's Name: _____ **Date of Birth:** _____

I understand that NO PROTECTED HEALTH INFORMATION (other than as outlined by the Health Insurance Portability and Accountability Act) can be released unless authorized. The parents or legal guardians of a minor patient will have access to the child's medical information, except when prohibited by law. If you would like to designate additional individuals to have this access, please include them below.

By signing this authorization, I authorize Carson Medical Group to disclose protected health information about my child to the following individual(s).

Please list each individual and mark the type of access you would like each individual to have.

Name: _____ Relationship: _____

☐ Appointment Information ☐ Billing Information ☐ Detailed Medical Information ☐ Pick Up Medical Records ☐ Accompany to Visits and Consent for Treatment

Name: _____ Relationship: _____

☐ Appointment Information ☐ Billing Information ☐ Detailed Medical Information ☐ Pick Up Medical Records ☐ Accompany to Visits and Consent for Treatment

Name: _____ Relationship: _____

☐ Appointment Information ☐ Billing Information ☐ Detailed Medical Information ☐ Pick Up Medical Records ☐ Accompany to Visits and Consent for Treatment

This authorization has no expiration date. It shall be terminated when withdrawn in writing or when an updated form has been completed.

Parent/Legal Guardian Name: _____
(Please Print)

Parent/Legal Guardian Signature: _____ **Date Signed:** _____