Joshi Pediatrics

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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

I, _____(name of parent or guardian), hereby authorize Joshi Pediatrics to:

Obtain medical records from the following facility:_____
_____

Release medical records to the following facility:___JOSHI_PEDIATRICS_____

For the patient(s) listed below:

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

Patient Name:_____DOB:_____

This authorization shall be in force and effective for 90 days.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Crystal Stadler at Joshi Pediatrics. I understand that a revocation is not effective to the extent that Joshi Pediatrics has relied on the use or disclosure of the protected health information. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. Joshi Pediatrics will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access to rights), refuse to sign this authorization, and/or receive a signed copy of this authorization.

_____ _____

Signature of Patient or Personal Representative Date