



AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION FROM TIGER PEDIATRICS

Patient Name _____ DOB _____

Address _____ City, State, ZIP _____ Phone Number _____

I, _____ hereby authorize Tiger Pediatrics to disclose medical records to:

The following:

Name of Institute _____ Phone Number _____

Address of Institute _____ Fax Number _____

- Complete Medical Record** (including: immunization records, growth charts, sick/well visits, lab reports, ordered x-rays, etc.)
- Basic Medical Record** (immunization records, sick/well visit summaries)
- Immunization Records Only**
- Other** (please specify) _____

I understand that protected health information release to a third party that is not subject to HIPAA regulations will no longer be protected, and may be subject to re-disclosure. Only providers of healthcare (organizations that provide medical or health services or medical supplies), health plans (organizations that pay for medical care), and healthcare clearinghouse (organizations that convert health data into the required format for electronic transmittal) are covered by HIPAA. I understand and I may revoke this authorization in writing at any time, but that revocation will not affect any prior authorized disclosures that have been taken by Physician.

This authorization shall be valid for (1) year. I hereby release Tiger Pediatrics from any and all legal responsibility or liability that may arise from the above actions authorized by myself.

X _____ Date: _____
Parent, Legal Guardian, or Legal Representative

Relationship to Patient _____

I understand that information in my health records may include information relating to sexually transmitted disease, acquired Immunodeficiency Syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Patient or Personal Representative must initial here _____ if disclosure of the information referenced above can be released.