FENTON PEDIATRICS, L.L.C.

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Notice: As set forth more fully in our Notice of Privacy Practices, we are required by law to obtain your authorization for any use or disclosure of your health information for purpose other than treatment, payment or health care operations. In our Notice of Privacy Practices, we provided you information about how Fenton Pediatrics can use or disclose your health information. You have a right to review our Notice of Privacy Practices before signing this Authorization.

I hereby authorize Fenton Pediatrics to: _____ **disclose/release to** _____ **obtain from**

_____

Name of Physician, Practice, Hospital or Entity

_____

Address

_____

Phone Fax

certain protected health information (PHI) of:

Patients Name: _____ Date of Birth: _____

Please check the appropriate individually identifiable health information to be released

___ Entire Record
___ Most Recent History and physical
___ Immunization Record
___ Laboratory results Dates from _____ to _____
___ X-ray and/or imaging reports Dates from _____ to _____
___ Consultation reports
___ Diagnosis Letter for LEP/504 Plan/Other
___ Other _____

I understand that this authorization may include information relating to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Syndrome (HIV) infection, Psychiatric Care, Behavioral or mental health services, Treatment for alcohol and/or drug abuse and Genetic Testing.

I understand that this information disclosed may be subject to re-disclosure by the recipient and no longer be protected by Fenton Pediatrics. Fenton Pediatrics and its staff are hereby released from any legal responsibility or liability for disclosure of the below information to the extent indicated and authorized herein.

This authorization will expire on _____ or 90 days from the date set forth below. In accordance with the procedures set forth in the Practice's Notice of Privacy Practices, when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice listed above has acted in reliance upon this authorization. My written revocation must be submitted to the practice above.

I acknowledge and understand that Fenton Pediatrics may not condition enrollment or eligibility for benefits upon my granting this authorization, unless the authorization is for their eligibility or enrollment determinations relating to me or for its underwriting or risk rating determinations; and the authorization.

Signature of Parent, Patient or Legal Guardian _____

Printed Name of Parent, Patient or Legal Guardian _____

Date _____ Relationship _____

Purpose for disclosure _____

Note to Recipient: This information has been disclosed to you from records whose confidentiality is protected by Federal and State laws (including HIPAA) and prohibits you from further disclosure without the written consent of the person to whom it pertains.

A copy of this form will be filed in the above named patient's PHI