AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Greenfield Pediatrics

460 Greenfield Ave. #12, Hanford CA 93230
Phone: (559) 582-4466 Fax: (559) 582-3019

Patient's Name: _____ Date of Birth: _____

Completion of this document authorizes the disclosure and/or use of individually identifiable health information as set forth below. **Failure to provide all information requested may invalidate this Authorization.**

I hereby authorize _____to use and
(Release from)
disclose a copy of the specific health information for the individual identified above to

_____
(Release to)

The request is made for the following purposes: *(Please check which applies)*

_____Personal Use
_____Attorney Use
_____Transfer Care
_____To obtain additional benefits
_____Payment of a claim
_____Other:_____

I specifically authorize the use and/or disclosure of the following health information to the extent such information and/or medical records exist. Please specify what health information that you would like to request:

Type of Information	[X] Check if Applicable	Applicable Dates with the Information
Visit History		
Immunization Records		
Laboratory Reports		
Radiology Reports		
Diagnostic Reports		
Billing Records		
Other:		

I understand that treatment, payment, enrollment or eligibility for benefits will not be denied based solely on my refusal to provide this authorization, unless the following applies:

- the treatment is research-related and the recipient identified above is seeking to use the information to conduct such research; or
- the recipient is a health plan which seeks to obtain information (except psychotherapy notes) in connection with my eligibility or future enrollment in the health plan; or
- the sole purpose of the treatment is to create health information to provide to the recipient identified above.

I understand that:

- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:

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- There may be exceptions where the revocation of the authorization may not be able to be honored.
- There is a potential for the information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer be protected.
- Any valid written revocation received by Greenfield Pediatrics shall not apply to information that has already been released pursuant to this authorization or affect actions taken by Greenfield Pediatrics prior to such written revocation.

This authorization will expire on date: _____.

_____ _____ _____AM/PM
Patient/Parent/Conservator/Guardian Date Time

Relationship to Patient: _____

_____ _____ _____AM/PM
Office Staff Witness Date Time