Grello Pediatrics P.C.

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AUTHORIZATION TO DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIFIC PURPOSE

DATE: _____

I authorize _____ **to release my medical records (PHI)**
(Practice Name)
indicated below.

TO: _____
(Name of Practice, Agency or Institution)

_____
(Address)

Describe the PHI information you want released, include dates of service or treatment period.

_____

_____

_____

I release Dr._____ from any laws related to disclosure of confidential or privileged information and understand that the information released may be subject to disclosure by the recipient and not protected by privacy laws. I understand I may not revoke for any actions taken by the office before receiving my written revocation.

Patient Name_____Date_____

Signature or Authorized Signature_____

Relationship to Patient_____