Pediatric Associates of Avon

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT'S NAME		DATE OF BIRTH
STREET ADDRESS		CITY, STATE, ZIP
PHONE NUMBER	SECONDARY PHONE NUMBER	

I hereby authorize PEDIATRIC ASSOCIATES OF AVON to obtain my child's health information FROM:

NAME OF AGENCY/FACILITY OR INDIVIDUAL(S)	
STREET ADDRESS	PHONE
CITY, STATE, ZIP	FAX

Health Information to be Released:

☐ Itemized Bill	☐ Office Visits/Progress Notes	☐ Pathology, Labs, Imaging Reports
☐ Operative/Procedure Reports	☐ Entire Record	☐ Specific Dates:

Purpose of Release:

☐ Personal Use	☐ Transfer of Care	☐ Insurance	☐ Legal	☐ Other (Specify):

• This authorization will expire 60 days from the date signed unless otherwise specified (not to exceed 180 days): _____

• I understand that I am not required to sign this Authorization in order to receive health care treatment.

By signing this form I authorize Pediatric Associates of Avon to obtain medical records from the entity listed above.

_____ _____

Patient or Legal Guardian Signature Date

_____

Relationship to Patient / Authority to Act on Patient's Behalf (Attach documentation)