



Willow Bend Pediatrics

Michael J. Frank, M.D., F.A.A.P.
Kimberly F. Mehendale, M.D., F.A.A.P.
Susan J. Sickler, M.D., F.A.A.P.
Shobha Michaels, M.D., F.A.A.P.
Janet S. Le, M.D.

TO: _____
Name of facility where records are to be released from

_____ Address Phone Number

_____ City State Zip

Standard Authorization of Use and Disclosure of Protected Health Information

Patient Name: _____ D.O.B. _____

I _____ authorize the following medical information to be released **to Willow Bend Pediatrics at the address below.**

Information to be disclosed:

- | | |
|--|--|
| <input type="checkbox"/> Medical History/Examination | <input type="checkbox"/> X-ray Reports |
| <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Growth Chart |
| <input type="checkbox"/> Laboratory Test Results | <input type="checkbox"/> Other (Specify) _____ |

Purpose of Disclosure of Medical Records:

- Further Medical Care Change of Physician

Expiration Date of Authorization

This Authorization is effective through ___/___/___ unless revoked or terminated by the patient or patient's personal representative.

We recommend you keep a copy of your medical records for your files.

Signature

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Patient or Personal Representative

Date