Willow Bend Pediatrics

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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:

__ Medical History/Examination
__ Immunization Records
__ Laboratory Test Results
__ X-ray Reports
__ Growth Chart
__ 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