Pediatric HIPAA Authorization Form

Patient Information

Patient Name

Date of Birth

Parent/Guardian Name

Relationship to Patient

Phone Number

Email Address

Authorization

I authorize the use and disclosure of the medical information described below:

Information to be released (check all that apply):

☐ Medical Records ☐ Immunization Records ☐ Lab Results ☐ Other

If Other, specify:

Purpose of Disclosure

Release To (Name of person or organization authorized to receive information):

Phone Number

Address

Expiration Date or Event

Additional Information/Restrictions

Signature & Date

Signature of Parent/Guardian

Date