Dr. Irma Romero MD

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Social Security #: _____
I request and authorize

Name: _____

Phone: _____ Ext: _____

Fax: _____

To release healthcare information of the patient named above to:

Kid's Place Pediatrics.

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ Immunization records only.

☐ Federal and State protected information: HIV/AIDS and related conditions, substance use, mental health, pregnant minors, and conditions reportable to the Health Department (DHO).

☐ Specified information only : _____

You have the right to revoke this authorization by putting it into writing. I understand that Kids place Pediatrics has the right to disclose as per "Notice of Privacy/Health Information Practices."

Patient Signature: _____ Date Signed: _____
Signature of Empowered Representative:_____
Date:_____ Relationship to Patient:_____
Witness Signature:_____ Date:_____

THIS AUTHORIZATION EXPIRES SIX MONTHS AFTER IT IS SIGNED.