WEST SIDE PEDIATRICS

AUTHORIZATION FOR RELEASE OF INFORMATION BY

PARENT OR LEGAL GUARDIAN

I understand that it is the policy of West Side Pediatrics, Inc. (the practice) to protect my child's privacy and to follow all state and federal privacy laws. However, I also understand in order to **involve other individuals in my child's medical care** it will be necessary for the practice to use/disclose some Protected Health Information ("PHI"). I understand that PHI to be disclosed may include information regarding genetic testing, HIV/AIDS status, mental health diagnosis and treatment, substance abuse diagnosis and treatment, pregnancies and/or pregnancy test results and I hereby specifically authorize the practice to disclose such information to the persons list below:

☐ I authorize West Side Pediatrics, Inc. to release and discuss my child's PHI including test and procedures to the following individuals:

Name: _____ Relation to patient: _____ Date: _____

Name: _____ Relation to patient: _____ Date: _____

Name: _____ Relation to patient: _____ Date: _____

PATIENT'S RIGHTS

I understand that I have the right to refuse to sign this Authorization to release PHI. If I refuse to sign this Authorization, the practice will in no way deny me my rights concerning treatment.

I understand that I may revoke this Authorization at any time after I have signed it by providing the Practice Manager with a written statement that I wish to revoke the Authorization. My revocation or Authorization will be effective immediately and PHI will no longer be used/ disclosed pursuant to this Authorization except when medically necessary in an emergency situation. This Authorization, unless I earlier revoke it, shall remain in effect for **as long as my child is an active patient at the practice.**

Parent(s) Name: _____

Signature: _____ Date: _____

Witness: _____