AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN HEALTH CARE PROVIDERS

Completion of this document allows the disclosure and/or use of individual identified records and health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient: ____ ____________________

Last First MI Date of Birth

I, the undersigned, do hereby authorize the use and/or release of protected health Medical Records for the above-named child's **from:**

Doctor's Name/Office: ____

Address: ____

Phone: ________________________________ Fax: ____

To the following:

Doctor's Name/Office: Avala Pediatrics

Address: 5959 Greenback Ln, Suite 210, Citrus Heights, CA 95621

Phone: (916) 722-4791 Fax: (916) 723-3388

The disclosure of health information is required for the following purpose:

Description of Information to be Disclosed: I authorize the release and disclosure of any and all medical records, histories, reports, notes, diagnostic films or imaging, and all such other health information pertaining to above mentioned patient, from: __________ [Date] to the date this release is presented for such records, to the persons/entities identified herein.

DURATION: This authorization shall become effective immediately and shall remain in effect until for one year from the date of signature, unless sooner revoked by me in writing.

YOUR RIGHTS:

I understand that I have the following rights with respect to this Authorization: I may revoke this Authorization at anytime. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care provider listed above. My refusal will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance to this Authorization. I understand that any use or disclosure made prior to the effective revocation under this authorization will not be affected by a revocation.

____ ____ ____________

Printed Name Signature Date

____ ____

Relationship to Patient Area Code and Telephone Number

Avala Pediatrics