AUTHORIZATION FOR USE AND DISCLOSURE OF PATIENT HEATH INFORMATION

I hereby authorize **ABC Pediatrics Fresno** to disclose all my protected health information to:

Name of Organization/Person: ____

Address: ____

Phone: ________________________ Fax: ________________________

Records and information pertaining to:

Patient Name: ____________________________________ **Date of Birth**: _________________

* Duration: This Authorization shall become effective immediately and shall remain in effect for 1 year.

* I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS, HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

* I understand that I have the right to revoke this authorization at any time in writing.

*Method of release of information can be mail, email, fax or pick up.

Signature of Patient or Legal Representative ____

Relationship to Patient ____ Date ______________, 2023

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