Beacon Pediatrics
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Authorization to Disclose Protected Health Information

Patient Name: _____ DOB: _____
Address: _____ Phone: _____

1. By Signing I hereby Authorize:

❑ **BEACON PEDIATRICS, LLC**
❑ Name of Physician/school Agency: _____
Address: _____
Phone: _____ FAX: _____

Purpose: ❑ Personal Use
❑ Transferring to another provider
❑ Sharing information w/another Provider
❑ Other: _____
_____

2. To Release the Following information TO:

❑ **BEACON PEDIATRICS, LLC**
❑ Name of Physician/school Agency: _____
Address: _____
Phone: _____ FAX: _____

❑Me

3. Description of information to be used or disclosed

❑ ALL RECORDS from: _____ to: _____ (dates must be entered) ❑ Lab Reports ❑ Hospital Reports
❑ Consult Reports ❑ Xray Reports ❑ Ancillary Service Reports ❑ Therapy Reports ❑ Drug/Alcohol Reports
❑ HIV/AIDS Reports ❑ Psychiatric/Psychology Notes ❑ Office Notes ❑ Immunizations ❑ Last Physical/Well Child Checkup
❑ Other: _____

By signing this authorization I understand the following:

1. I understand the Physician/School/Agency that I am requesting my records from may charge a fee for processing and copying my records. I understand that if there is a payment required I am responsible to pay the fee before my records can be transferred to the office listed above. I understand I will make contact with my previous Physician/School/Agency in regards to fees and time allotment for receiving records. _____(Parent/Responsible Parties Initials)

2. I understand that I may revoke this consent in writing at any time except to the extent that action on this authorization has not already occurred and that my records are protected under federal regulations.

3. This authorization becomes effective: _____ and will expire on: _____

****If you have guardianship or legal custody, proper legal documentation must be present with this request in order for request to be granted****

_____ _____ _____
Signature of Patient/Parent/Legal Representative | Relationship to Patient | Date