Beacon Pediatrics

18947 John J Williams Hwy. Suite 212
Rehoboth Beach, DE 19971
P: (302) 645-8212 F: (302) 645-2199

32566 Docs Place, Suite 1
Millville, DE 19967
P: (302) 537-0793 F: (302) 537-0795

Authorization to Disclose Protected Health Information

Patient Name: _____ ❑**M** ❑**F**
DOB: _____ **Phone:** _____
Email:_____
Address: _____
City/state/zip

Incoming to Beacon

❑ I authorize the release of my child(ren)'s PHI to :
Beacon Pediatrics (Please select which location)

❑ 18947 John J Williams Hwy. Suite 212
Rehoboth Beach, DE 19971

❑ 32566 Docs Place, Suite 1 Millville, DE 19967

FROM:_____
Office Name
Address:_____
City/state/zip
Phone: _____

Fax: _____

Outgoing

❑ I authorize **Beacon Pediatrics** to release my child(ren)'s PHI :

TO:_____
Office Name
Address:_____
City/state/zip
Phone: _____

Fax: _____

Reason for request:
❑ Transferring to another provider
❑ Personal Use
❑ Sharing information w/another Provider
❑ Moving Out of the Area
❑Other:_____
_____

Information to be Released

❑ ALL RECORDS from: _____ to: _____ (dates must be entered)

❑ Other:_____
_____
_____

By signing this authorization I understand the following:

- ❑ **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)**
- ❑ **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.
- ❑ 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**