Authorization for use or disclosure of protected health information

I, _____, **authorize** _____ (facility name) **to release**:

☐ my health information (DOB__/__/__)

☐ my minor child(ren)'s or patient for whom I am the authorized representative

Name _____ DOB __/__/___ Name _____ DOB __/__/___

Name _____ DOB __/__/___ Name _____ DOB __/__/___

as described below, to the following medical facility:

Einstein Pediatrics, PLLC
2235 Cedar Lane, Suite 302
Vienna VA 22182
Phone 703.344.7330 Fax 703.344.7309

DESCRIPTION OF INFORMATION:

I request that the information from dates_____ to _____to be used or disclosed consist of the following **CHECK ALL THAT APPLY**:

□ **Children < 1-year-old**: entire medical record

□ **Children 10 and above**: last well visit, last 2 sick visits, last year of labs and specialist reports, growth charts, and vaccines

□ **Summary of Records**

□ **Children 1 -10 years old**: last 2 well visits, last 2 sick visits, all labs, growth charts, and vaccine records and specialist reports

□ **Children with Chronic Disease**: All specialist reports, labs, and radiological studies in past 2 years

□ **Entire Medical Record**

EXPIRATION: This authorization will expire automatically 1 year on the date following signature or event that relates to me or the purpose of disclosure.

INDIVIDUAL'S RIGHTS RELATING TO THIS AUTHORIZATON:

I understand I may revoke this authorization by notifying the Medical Practice at any time in writing. I may refuse to sign this authorization. My health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form. I have a right to receive a copy of this form after I have signed it. By signing this authorization form, I authorize the use or disclosure of my protected health information as described above. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I have had an opportunity to review and understand the content of this authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

_____ _____

PATIENT'S OR REPRESENTATIVE'S SIGNATURE PRINTED NAME

_____ _____ _____

REPRESENTATIVE'S RELATIONSHIP (IF APPLICABLE) DATE CONTACT #