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Authorization to Release Protected Health Information

I _____ (*please print name*), the parent/guardian of
_____ (*patient name*), _____ (*date of birth*), hereby authorize

Christopher Kye, MD to: _____ release information to: _____ obtain information from:

Name: _____ Relationship: _____
Name of physician, therapist, school, hospital, individual, etc

Address: _____

Phone number: _____ Fax number: _____

	History and physical examination		Radiology, EKG/EEG reports
	Provider progress notes		Special procedures
	Medication records		Financial account information
	Laboratory reports		Other
	Discharge summary and instructions		Entire chart

I understand that this information may include records including alcohol or substance abuse, pregnancy, sexually transmitted diseases (STD) acquired immune deficiency syndrome (AIDS), and/or HIV status, mental health records and/or other “sensitive information”

I UNDERSTAND THAT THIS AUTHORIZATION IS:

- For verbal and written communication about my complete medical records, including all labs, radiology reports, EKG imaging, consult reports, progress notes, and medication records.
- Remains in effect indefinitely unless otherwise specified by me
- Is voluntary and my treatment and fees are not conditional on my signing this authorization

I FURTHER UNDERSTAND:

- If I no longer want information to be shared between Dr. Kye and any of the individuals named above, I have the right to revoke this authorization at any time. I must notify Dr. Kye in writing to do so.
- Written revocation does not affect any disclosures of medical information that have already been discussed.

By signing below, I acknowledge that I have read this document in full and understand the terms of this authorization to verbally discuss my health information. All of my questions have been answered satisfactorily.

(Signature of parent or legal representative)

_____/_____/_____
(Today's date)