Agave Pediatrics
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Authorization for the Use or Disclosure of Health Information

- ○ Release
- ○ Request

Patient Name: _____ Date of Birth: _____
Patient Name: _____ Date of Birth: _____
Patient Name: _____ Date of Birth: _____
Patient Name: _____ Date of Birth: _____

I request/release of my child's health information:

Office Name: _____
Doctor's Name: _____
Address: _____
_____
Phone: _____
Fax: _____

The health information to be used/disclosed includes: (check all that apply)

1) _____ All health information including but not limited to AIDS/HIV and other communicable disease information, behavioral health care/psychiatric care, alcohol and or drug abuse treatment, if any, unless specifically stated: _____
2) _____ Health information relating to the following condition:

_____

3) _____ Health information for the date(s): _____
4) _____ Immunization record

I hereby request and consent that my medical records and non-written records be sent to my referring physicians, those physicians or ancillary facilities that I am referred to by Agave Pediatrics and to my insurance company or its agents that may be authorizing treatment. I further understand that I do not have to sign this authorization in order to get health care benefits. I understand that I may revoke this authorization in writing at any time except to the extent that Agave Pediatrics has acted in reliance upon this authorization. Once this office discloses health information, the person or organization that receives it may re-disclose it (dependent on their policy) and Agave Pediatrics does not take responsibility for the protection of this information. ***This authorization is valid for one time use only and will only be valid for 30 days from signature date. Valid government issued ID is required for processing of any records request to verify the identity of parent/legal guardian.***

Signature of parent/legal guardian: _____
Date: _____
Relationship to Patient: _____