Permission to Discuss Protected Health Information

*****COMPLETION OF THIS FORM IS OPTIONAL*****

Patient Name	Date of Birth	
Patient address	State	Zip
City	Phone number	

I give permission to Pediatricenter to discuss the following medical and billing information about me *(check all boxes that apply)*:

- □ Scheduling/Appointment information
- □ Medical information, including my symptoms, diagnosis, medications and treatment plan
- □ Behavioral health information, including my symptoms, diagnosis, medications and treatment plan
- □ Lab/test results
- □ Billing and payment information
- □ Other (describe): _____

Pediatricenter has my permission to discuss the above information with:

1. Name _____

Phone number_____

2. Name _____

Phone number_____

I understand that I have the right to revoke my permission at any time except where Pediatricenter has already made disclosures in reliance upon this request.

I understand that I must notify Pediatricenter in writing if I want to revoke my permission.

I understand that unless otherwise revoked this authorization form will expire one year from the date of signature

Signature of Patient X_____ Date_____

—Completion of this form is optional—

Physician may seek additional consent from a patient to discuss certain topics with parents even if this form is signed.