AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize _____ to disclose a copy of the specific health and medical information described below regarding:

Patient Name:_____

To:

North Willow Grove Pediatrics
2510 Maryland Rd #160
Willow Grove PA 19090
215-672-6622 (P)
215-672-6566 (F)

Recipient Name:_____

Please disclose the following:

___ Most recent well visit
___ Growth Chart
___ Immunizations
___ Problem List
___ Medication List
___ Other
___ Hospital Newborn
___ Newborn Screen

Purpose of Disclosure: **Transfer**

The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This form summarizes the anticipated use of information regarding your child for which this authorization is required.

I understand that I have the right to revoke this Authorization at any time prior to the Practice's compliance with the request set forth herein, provided that the revocation is in writing. However, such a revocation shall not affect any disclosures that have already been made due to your prior authorization.

I understand that the above mentioned information disclosed may be subject to re-disclosure by the recipient listed above and, in that case, will no longer be protected by HIPAA.

This authorization expires upon the Practice's release of the information described above or ninety (90) days after the Date of Authorization, whichever comes first.

I hereby acknowledge receipt of a copy of this Authorization

Signature:_____

Relationship to Patient:_____ Date of Authorization:_____