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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT: _____ BIRTHDATE: _____

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I authorize Kiwi Pediatrics Medical Group to release protected health information to the following healthcare provider/facility.

Name: _____

Address: _____

**This authorization applies to the following information unless otherwise stated:
Problem List, Current Medications, Pertinent Medication History, Immunizations,
Growth Records (growth charts), Pertinent Diagnostic Studies, Pertinent
Consultations**

- *I understand the information in the health record may include information relating to sexually transmitted disease, including HIV, It may also include information about behavioral/mental health and drug or alcohol abuse.*
- Other: _____

From (check which applies): all dates of service dates: _____

This health information is requested by the patient/patient representative for the purpose of ongoing care unless otherwise stated here: _____.

Kiwi Pediatrics is required by law to keep your health information confidential. This authorization to release health information is VOLUNTARY and may be revoked at any time. The revocation will take effect when Kiwi Pediatrics receives it. I understand that treatment, payment, or eligibility for benefits will not be affected if I do not sign this authorization.

Redisclosure: California law prohibits the entity receiving this health information from further disclosure without appropriate authorization unless specifically required or allowed by law.

Expiration of Authorization: Unless otherwise revoked, the authorization will expire 12 months after the date of my signing this form or on the following date: _____

I have the right to receive a copy of this authorization and the health information being disclosed.

print name

signature

date