



Willow Bend Pediatrics

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TO: _____
Name of facility where records are to be released from

Address Phone Number

City State Zip

Standard Authorization of Use and Disclosure of Protected Health Information

Patient Name: _____ D.O.B. _____

I _____ authorize the following medical information to be released **to Willow Bend Pediatrics at the address below.**

Information to be Disclosed:

- Medical History/Examination
- Immunization Records
- Laboratory Test Results
- X-ray Reports
- Growth Charts
- Other (Specify) _____

Purpose of Disclosure of Medical Records:

- Further Medical Care
- Change of Physician

Expiration Date of Authorization

This Authorization is effective through ___/___/___ unless revoked or terminated by the patient or patient's personal representative.

We recommend you keep a copy of your medical records for your files.

Signature

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Personal Representative Date _____ Signature of Patient or