Kid Approved Pediatrics, PLLC
11875 Coit Rd, Ste 100
Frisco, TX 75035

(YOUNG ADULT) PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO ANOTHER INDIVIDUAL(PARENT)

Date: _____

Patient Name: _____

Date of Birth: _____

Description of the specific information to be used or disclosed: (Please check one of the following):

____ All Information

Or Specific information like the following: ____ Pick up Patient Records

____ Cancel, reschedule, make appointments for patient

____ Call to get Patient's results

____ Pick up patient's medicine/samples

Write names of people we can give out information to and the relationship to them. If you **Do Not** want us to release any information to anybody, just cross out the page.

Name: _____ Relationship: _____ Phone:_____

Name: _____ Relationship: _____ Phone: _____

I understand that: I may inspect or copy the protected health information to be used or disclosed. I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer. Information used or disclosed pursuant to the Authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA.

Patient Signature: _____

Date:_____ Phone number:_____