Authorization to disclose Health Information

I hereby authorize the use or disclosure of information from the medical record of patient:

Patient Name_____ **Date of Birth**_____

To / From (circle one)	**To / From (circle one)**
Kessler Pediatrics	**Organization** _____
1411 N. Beckley Ave, Suite 164	**Address** _____
Dallas, TX 75203	_____
(214) 941-6691 (office)	**Phone** _____
(214) 941-0437 (fax)	**Fax** _____

Please release the following:

___ Entire Record (including Labs, X-rays etc.) OR

_____ Newborn Hospital Assessment Record
_____ Immunization Record Only
_____ Most recent Office Notes

Purpose for the Release:

_____ Continuity of Medical Care _____ Transferring Primary Care Physicians _____ Legal Purposes

By signing below, you hereby consent for **Kessler Pediatrics** to use and/or disclose information about yourself (or another person for whom you have authority to sign) that is protected under federal law, for the sole purposes to treatment, payment, and heath care operations. You may refuse to sign this consent form.

You should read the **Notice of Privacy Practices** for **Protected Health Information** attached to this form before signing the consent. The terms of the Notice may change from time to time, and you may request a revised copy by asking the Privacy Office at **Kessler Pediatrics.**

You have the right to request that **Kessler Pediatrics** restrict how **Protected Health Information** is used or disclosed to carry out treatment, payment, or health operations. **Kessler Pediatrics** is not required to agree to requested restrictions; however, if Kessler Pediatrics agrees to your requested restriction, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognized that the **Protected Health Information** used or disclosed pursuant to this consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

You may communicate with the following individual(s) regarding my child's condition or course of treatment:
_____.

You may communicate confidential information to me, including invoices for services, to the following address and/or phone/fax numbers:_____.

_____ Date_____

Signature of patient or Legal Representative

_____ _____

Relationship to Patient Witness