RELEASE OF PROTECTED HEALTH INFORMATION

I authorize _____ to release the medical records for:

Patient Name: _____
Date of Birth: _____
Address: _____
Phone: _____

Records may be released to:
Name/Organization: **Fisher Pediatrics**

Records to be released:
☐ Complete medical record
☐ Specific records: _____

Purpose of Release:
☐ At the request of the patient/parent/guardian
☐ Other: _____

DIGITAL RECORDS ONLY

Please send records **electronically/digitally by USB.** Records may also be sent directly to the patient and the patient can upload them to their FollowMyHealth portal. Please mail paper copies directly to the patient.

DO NOT FAX RECORDS.

I understand that this authorization may be revoked in writing at any time. Revocation will not affect information already released.

This authorization expires **60 days after the date signed**, unless a different expiration date is written below.

Expiration Date: _____

Patient/Parent/Guardian Signature: _____
Date: _____