Authorization for Release of Information to Schools and Daycares

Must be completed for all authorizations

I hereby authorize the use of disclosure of my health information as described below.

By signing this authorization, I authorize Charleston Pediatrics to use and/or disclose certain protected health information(PHI) about me or my child to the entity below.

Patient Name: _____ DOB: ____/____/____

Patient Name: _____ DOB: ____/____/____

School/ Daycare Name: _____ Phone#: ____-____-_____

Address: _____ City: _____ State: _____

Zip code: _____

This authorization permits Charleston Pediatrics to use and/ or disclose the following identifiable health information about me or my child as requested by school, daycare or parent via mail, phone or fax:

Immunization Certificates, School excuses, School forms and Medication Instructions

I do not have to sign this authorization in order to receive treatment from Charleston pediatrics. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy officer at:

198 Rutledge Ave. Suite 1
Charleston, SC 29403

I understand that this authorization is valid from date signed, unless revoked in writing.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Relationship to the patient