HARMON PEDIATRICS • 185 East 85th Street Office 1 • New York, NY 10028

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, ______________________________, hereby authorize, Harmon Pediatrics- 185 East 85th Street
(Name of patient or legal representative)

Office 1, New York, NY10028 to release the following heath records of :

____
Child/Children's name and date(s) of birth

Including: Entire Medical records- patient histories, office notes, test results, radiology studies, consults, records sent by other health care providers

To: ____
(Name, title, or facility and address to receive health/medical information)

____

For the following purpose: ______________________________

This authorization is valid for 24 months following the date of my signature shown below.

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke the authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization. I have read this authorization and I agree to its term as indicated by my signature below.
- The above recipient organization/person, its representatives or other persons performing services for them on their behalf, may need to obtain, use or disclose any and all information about my physical and mental health including but not limited to, services for preventative, diagnostic and therapeutic care, tests, counseling and medical prescriptions for the purpose of change of doctor, specialist referral, insurance purposes Continued treatment or legal investigation.

______________________________	____________	______________________________
Signature of patient/legal representative	***Date Signed***	*Description of Representative's Authority*
		Parent/Legal Guardian