Children's Cardiology of the Bay Area
2051 Pioneer Court, San Mateo, CA 94403
Phone: (650) 558-8280 ~ www.mykidsheart.com

Complete mail or fax this form to (650) 558.8281

Authorization for Use or Disclosure of Information for Purpose Requested by Physicians

I, _____, hereby authorize Children's Cardiology of the Bay Area to disclose the following protected health information to;

_____ _____
(name of entity / person to receive information) (Fax number required)

Describe the information such as date of service, type of service provided, and level of detail to be released: _____

_____

This protected health information is being used or disclosed for the following purposes: _____

This authorization shall be in force for one (1) year from the date signed at which time this authorization to use or disclose this protected information expires. The recipient may not further use or disclose the health information unless another authorization is obtained. I understand I have the right to request a copy of this authorization.

I understand I have the right to revoke this authorization, in writing at any time by sending notification to Children's Cardiology of the Bay Area at the above address.

Parent signature: _____ Date: _____

Print child's name: _____

Child's Date of Birth:_____

In case of questions I can be contact at: (_____)_____

My mailing address is: _____

_____

~ Please note mailing records/information <u>may</u> require a $25.00 fee ~

My email address is: _____

PLEASE PRINT EMAIL ADDRESS ~ (NO FEE)

PLEASE ALLOW 2 WORKING DAYS FOR RECORDS TO BE SENT