REIS PEDIATRICS

KAILUA PROFESSIONAL CENTER I | 30 AULIKE ST, SUITE 500, KAILUA, HI 96734 | 808.263.8822 WWW.REISPEDIATRICS.COM

RECORDS RELEASE AUTHORIZATION (OUTGOING PATIENTS)

I AUTHORIZE REIS PEDIATRICS TO RELEASE PROTECTED HEALTH INFORMATION TO:

Name of Healthcare Provider: _____

Address: _____

Telephone Number: _____

Fax Number: _____

___ All Healthcare Information

___ Immunization Record Only

___ Lab Report(s) Date(s) _____

___ Consultation Note(s) Date(s) _____

For the following patients:

Child/children's name(s) and date(s) of birth: _____

_____

Parent's name: _____

Address: _____

Phone number: _____

Reason for leaving Reis Pediatrics: _____

Signature: _____ Date: _____

This Authorization will expire 90 days after the date identified above. You can cancel this authorization at any time, but you must do so in writing. If you cancel it, the people authorized to use and disclose your protected health information may use the information collected prior to the date you revoked this authorization. Please send written revocation to the individual or department who you authorized to use your protected health information. Also, please be aware that once we disclose this information per your instructions, the information is subject to re-disclosure and may no longer be protected.

Office Use Only

Outstanding Patient Balance: _____ Outstanding Insurance Balance: _____

Date Payment Collected:_____ CA CC CK

Date Faxed:_____