AUTHORIZATION TO RELEASE INFORMATION

Patient Name_____ **DOB**_____
Address_____

Phone# _____, **Fax#**_____ I hereby authorize

_____to make uses and disclosure of

my child's protected health information to the following entity:

Kenneth M. Klebanow, M.D. & Associates, P.A. 8821 Columbia 100 Parkway Columbia, MD 21045

Phone# 410-997-1700, Fax (410)-740-8315

Description of information to be disclosed:

- Complete records to include yours and any medical records that had been sent to you from previous providers including mental health, HIV, and/or substance abuse records. (Cross out any item you do not authorize to be released).
- Records regarding treatment for the following condition or injury _____
- Records covering the period of time from _____ to _____
- Other (Please specify-include dates) _____

Reason For Requested Use Or Disclosure:_____

To Be Read And Signed By The Parent Or Guardian:

1. I may revoke this authorization at any time by providing written notice to the practice.
2. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization.
3. The practice will not condition treatment or payment based on my signing this authorization.
4. I am signing this authorization freely and no one has pressured me to sign it.
5. The information disclosed in this authorization may be subject to redisclosure by the practice and no longer protected by federal law.
6. I acknowledge that I have had an opportunity to review this authorization and understand the intent and the use.
7. I have received a copy of this authorization.

Parent or Guardian's Signature _____

Relationship to the Patient _____**Date** _____