Patient Information Release

In accordance with the new Federal and HIPPA (Health Insurance Portability and Accountability Act) regulations, any medical information pertaining to you will only be disclosed to the person(s) indicated below. If they are not listed below, no information will be disclosed at any time. Thank you for your cooperation.

This is to certify that I, _____ parent of _____ authorize The Children's Health Center to disclose my child's medical information to the following person(s) only:

Name	Relationship

____ I DO NOT WISH to have any of my child's health related information released to anyone other than myself. (Please initial if this is your selection)

Signature:

_____

Any changes of patients release information MUST BE IN WRITING ONLY.