AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: ____ **DOB:** ________________________

PLEASE, READ THOROUGHLY: (NOTE: PROVIDE ACCURATE & COMPLETE INFORMTION. **EXAMPLE:** IF THE DOB IS INCORRECT, THIS CAN DELAY PROCESSING YOUR REQUEST)

By my signature below, I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Provider/ Organizations providing the information: (If an organization does not have a website set up or has not been updated) Please include PHONE, FAX number & ADDRESS. *** please print clearly and legibly**	**Persons/ Organizations receiving the information:** **Journey Pediatrics** 8308 Constitution Pl. NE, Albuquerque, NM 87110 Ph: (505) 883-9570 / **FAX (505) 883-4163**
	Purpose of requested use or disclosure: ☒ **Continuing Care**
Specific description of the information:	
☒ All Records (**Provide your address & new phone number - if you have moved to a new location or if you are planning to move out of state).**	

The patient or the patient's parent/guardian must read date and initial the following statements:

		Initials
1.	I understand that this authorization will expire on ______ /______ / _________. If I fail to specify an expiration date, this authorization **will expire in six months**.	
2.	I understand that I may revoke this authorization at any time by notifying the providing organization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization and will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.	
3.	I understand that my healthcare and the payment for my health care will not be affected if I do not sign this form.	
4.	I understand that I may see and copy the information described on this form and will receive a copy of this form after it is signed.	
5.	If I have questions about disclosure of my health information, I can contact the office staff or the physician.	

____ ________________________

Signature of Patient or Parent/ Guardian **Date**

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Print your Name - Parent/ Guardian (please print clearly and legibly)

This document will be retained by the providing organization for six years.