

Permission to Discuss Protected Health Information

*****COMPLETION OF THIS FORM IS OPTIONAL*****

Patient Name	Date of Birth	
Patient address	State	Zip
City	Phone number	

I give permission to Pediatricenter to discuss the following medical and billing information about me (check all boxes that apply):

- Scheduling/Appointment information
- Medical information, including my symptoms, diagnosis, medications and treatment plan
- Behavioral health information, including my symptoms, diagnosis, medications and treatment plan
- Lab/test results
- Billing and payment information
- Other (describe): _____

Pediatricenter has my permission to discuss the above information with:

1. Name _____

Phone number _____

2. Name _____

Phone number _____

I understand that I have the right to revoke my permission at any time except where Pediatricenter has already made disclosures in reliance upon this request.

I understand that I must notify Pediatricenter in writing if I want to revoke my permission.

I understand that unless otherwise revoked this authorization form will expire one year from the date of signature

Signature of Patient **X** _____ **Date** _____

—Completion of this form is optional—

Physician may seek additional consent from a patient to discuss certain topics with parents even if this form is signed.