AUTHORIZATION FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

This authorization permits receipt and/or disclosure of the following individually identifiable health information about me or my child:

To Elemental Pediatrics LLC
116 N. Main St.
Plattsburg, MO 64477-1236
Phone: (816) 704-5800 Fax: (816) 704-5793 Secure email: info@elementalpediatrics.com

These records should be released:

From: _____
_____
_____

Fax: _____

Records to be released: ☐ Immunization Record ☐ Growth Chart ☐ Laboratory/X-ray reports
☐ Complete Medical Record including immunization data and other physician reports
☐ Consultant / Other Physician Reports ☐ Mental Health Information ☐ HIV/AIDS test results
☐ NOTE: MUST INCLUDE C-CDA or CCD if from an electronic health record
Dates: ☐ All ☐ ___/___/___ to ___/___/___ Authorization Exp. Date (1yr unless noted):___/___/___

The information released will be used for the following purpose: ☐ Medical Care
☐ At the patient/guardian's request ☐ Other:_____

Note that signing this form is not required to receive treatment from Elemental Pediatrics LLC (EP). In addition, EP may send, receive, and/or use personal health information as legally allowed with or without this form being signed. This authorization may be revoked at any time by submitting written instructions for such to EP except to the extent that EP may have already acted in reliance on this authorization.

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Date of Birth

_____ _____
Print Name of Patient or Legal Guardian Signing Above Today's Date

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