PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize Tenafly Pediatrics to use and/or disclose my protected health information (PHI) about me to or for the parties listed below.

This authorization permits Tenafly Pediatrics to use or disclose to:

_____

_____

the information in my medical chart with the following exceptions (please check if applicable):

___ information regarding sexual activity

___ information regarding drug use

___other (please specify):_____

I have the right to revoke this authorization in writing except to the extent that Tenafly Pediatrics has acted in reliance upon this authorization. My written revocation must be submitted to Tenafly Pediatrics' Privacy Officer.

Signed by: _____

Signature of Patient

Patient's Name:_____ Date: _____

Patient's Cell: _____ Patient's Email: _____