OAKBROOK PEDIATRICS, P.A.
Authorization for Release/ Request of PHI

Patient Name____ Date of Birth __________________

I authorize Oakbrook Pediatrics to use/ release information on the above named individual.

__ (REQUEST) use protected health information
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send to: Oakbrook Pediatrics, P.A.
202 Benton's Lodge Road
Summerville, SC 29485

PH (843) 871-2588 FAX (843) 871-1664

__ (RELEASE) disclose protected health information to: ____

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Information to be used or disclosed: ☐ Entire Chart ☐ Other

I understand this information may include reference to (check all that apply):

- ☐ psychiatric/psychological care (ADD/ADHD)
- ☐ drug abuse
- ☐ sexual assault
- ☐ results of tests for infectious diseases including HIV/AIDS
- ☐ alcohol abuse

The purpose of the disclosure is: ☐ Treatment

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I understand I have the right to cancel /revoke this authorization at any time. I understand that if I cancel/revoke this authorization I must do so in writing directly to the practice Privacy Contact person, Lisa Legates at 202 Benton's Lodge Road, Summerville, SC 29485. The phone number is (843) 871-2588. Unless otherwise notified this authorization will expire 90 days from this date.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal law and that a reasonable fee will be charged as outlined in the Notice of Privacy Practices. I can also refuse to sign this authorization. I also understand my records may be sent by mail or via fax machine.

____ ______________________
Signature of Parent/ Legal Representative Date

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Printed Name of Parent/ Legal Representative

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Relationship to Patient