PORTOFINO PEDIATRICS

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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, _____ (Parent/ Guardian/ Legal Representative), authorize:

Doctor/ Practice's Name: _____

Doctor/Practice's Address: _____

Phone #: _____ Fax #_____

To disclose health information about my child:

Name: _____ DOB: _____

I consent to the release of the Health Information initialed below:

- ☐ Case Management Records
- ☐ Labs Reports
- ☐ Radiology Reports
- ☐ Last Preventive Care Visit
- ☐ Clinical Notes
- ☐ Immunization Records
- ☐ Discharge Summary
- ☐ Consultations
- ☐ Operative Notes
- ☐ Therapy/ POC Notes
- ☐ Mental Health/ Counseling Notes
- ☐ Psychiatrist Notes
- ☐ Other (specify): _____

For the purpose of:

- ☐ Continuation of Treatment
- ☐ Legal Review
- ☐ Insurance Purpose
- ☐ Personal Review of Information

I understand that I may refuse or may revoke (at any time) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation of care or quality of treatment.
I choose to have this consent to expire on the following date, event or condition: _____.
Otherwise, this consent will remain valid for twelve (12) months from the date this consent was signed.

_____ _____

Parent/ Guardian/ Legal Representative Signature | Date

_____ _____

Print Name | Phone #