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## Partners In Pediatrics

### Patient Authorization Form for Use and Disclosure of Protected Health Information

By signing this authorization, I authorize Partners In Pediatrics to disclose certain protected health information about my child.

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Print Patient's Name                      Date of Birth

Please list below the information to be disclosed:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- Please fax to (name and number) \_\_\_\_\_
- I will pick up on \_\_\_\_\_
- I have enclosed/left a self addressed, stamped envelope for information to be mailed to: \_\_\_\_\_

Please give us a contact name and phone number in case we have any questions:

\_\_\_\_\_

Signed by: \_\_\_\_\_

Signature of Legal Guardian                      Relationship to Patient

\_\_\_\_\_

Print Name of Legal Guardian                      Date