AUTHORIZATION TO SHARE HEALTH INFORMATION

Patient Name: _____
Date of Birth: _____
Phone Number: _____

I hereby authorize **Westside Pediatric Clinic, P.C.** to share my protected health information with the following individual(s):

1. **Name:** _____
   Relationship to Patient: _____
   Phone Number: _____
2. **Name:** _____
   Relationship to Patient: _____
   Phone Number: _____
3. **Name:** _____
   Relationship to Patient: _____
   Phone Number: _____

Information to be Shared (Check All That Apply):

☐ Appointment details (scheduling, cancellations)
☐ Medical records, test results, and treatment plans
☐ Billing and insurance information
☐ Medication and prescription details
☐ Other (please specify): _____

Purpose of Disclosure:

☐ Ongoing medical care coordination
☐ Insurance and billing assistance
☐ Other (please specify): _____

I understand that:

- This authorization is voluntary, and I may revoke it at any time by providing a written request to Westside Pediatric Clinic, P.C.
- Revocation will not apply to information already released under this authorization.
- This authorization expires **(select one):**
  ☐ On this date: _____
  ☐ One year from the date of signing
  ☐ Until revoked by me in writing

Signature of Patient (18+): _____ **Date:** _____