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————— Dr. Reba Beard ————— Laura Shao, PA-C ————— Dr. Betty Harmon —————

AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ **DOB:** _____

I hereby authorize **SUNRISE PEDIATRICS** to RECEIVE DISCLOSE

the following information to:

Name of Facility/Individual: _____

Address: _____

Phone: _____ **Fax:** _____

Information to be shared:

Entire Medical Record Encounter date(s) _____ to _____

Other: _____

The information may be disclosed for the following purpose(s) only:

Insurance Continued Treatment Legal At my or my representative's request

Other: _____ Relationship: _____

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

Signature of Patient/Legal Guardian/Representative: _____

Relationship to Patient: Self Mother/Father Other: _____

Signature Date: _____ Expiration Date of Authorization: *three (3) years.*

*Please note: we are unable to read discs. **Please fax or mail paper records only.**
If neither of these options are available, records can be sent to: records@sunrisepediatricsok.com.*