Authorization to Fax/Disclose Protected Health Information (PHI)

(this form to be used if sending information to a third party. E.g. school or daycare)

Date: _____

Patient's Name: _____

Patient's Birth Date: _____

- o I hereby authorize SOUTH EAST BAY PEDIATRIC MEDICAL GROUP to FAX the following information:

  - o Immunization records
  - o School/daycare registration forms
  - o School excuse forms
  - o Medication forms for school
  - o Lab results
  - o Sports form
  - o Other:

_____

_____

to the following:

Name: _____

Phone Number: _____

Fax Number: _____

The reason for my request is:

_____

Parent Signature: _____ Phone: _____

Parent Name: _____

○ mother ○ father ○ other _____

Entered into Disclosure Log on date: _____ by: _____

THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE ABOVE DATE.

I do not have to sign this authorization to receive treatment from South East Bay Pediatric Medical Group. I have the right to refuse to sign this authorization. After information is transferred or disclosed TO the physician or entity listed above, it may be transferred or disclosed again BY the physician or entity listed above. I have the right to revoke this authorization. If I revoke this authorization, no further transfer or disclosure of my information will occur. *Any information that has been transferred or disclosed after the date of this authorization, but before the date of revocation, will not be affected by the revocation.* My revocation must be submitted in writing to:

South East Bay Pediatric Medical Group
2191 Mowry Ave, Ste. 600C, Fremont CA 94538
Ph. (510) 792-4373 Fax (510) 792-3420

(January 2019)