HIPAA AUTHORIZATION FORM FOR PATIENTS 18 AND OVER

I, _____, authorize Peak Pediatrics to discuss my medical care and information with the following individuals. I understand that medical information includes test results, radiology results, medical diagnosis, active or discontinued medications. Furthermore, I grant Peak Pediatrics permission to disclose medical information that is relevant to my care such as appointment changes and/or billing information:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

I give Peak Pediatrics permission to leave me a detailed message on the following phone number(s):

☐ Mobile Phone #: _____ ☐ Home Phone #: _____

I understand that I may terminate this HIPAA Authorization Form at any time by submitting a request in writing to Peak Pediatrics.

Patient's Signature: _____ Date: _____