HIPAA AUTHORIZATION FORM

I, _____, authorize Peak Pediatrics to share my child's protected health information with the following individuals who may be involved in my child's care. I understand that I am responsible for notifying Peak Pediatrics of any changes. The name(s) listed below are family member(s) or friends to whom I grant permission for Peak Pediatrics representatives to verbally discuss my child's care using their best judgment and grant them permission to disclose medical information that is relevant to my child's care such as appointment changes, billing information and/or needed treatment:

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 #: _____

Furthermore, I authorize the following individual(s) to bring my child in for appointments and allow them to authorize medical treatment for my child by Peak Pediatrics. I understand that co-payments are due at the time of service, and that I am responsible for payment for services rendered:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

This HIPAA Authorization Form pertains to the following children:

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

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

Parent/Legal Guardian's Signature: _____ Date: _____