



DISCLOSURE AUTHORIZATION

- I give permission to leave voicemail messages on my phone, including information about test result availability for my child, follow-up requirements, health inquiries and test results.

- I give permission to fax or otherwise send my child's medical records to me including test results, x-ray reports and/or the encounter note. I understand that some methods of delivery may not be secure and could affect the privacy of my child's personal health information.

- I give permission to fax or otherwise communicate with my child's school including providing my child's personal health information to the school for attendance related questions and to authorize or limit my child's participation in school activities including sports.

Patient: _____

Guardian Name/Relationship to Patient: _____

Guardian Signature: _____

Guardian contact telephone number: _____

Please fax back to the office the patient was seen in with copy of photo ID to (407) 612-4017