Authorization to Securely E-mail Protected Health Information

I give my permission to release the health information of:

Patient Name: ____**DOB:**____________________

Street Address:____

City/State/Zip:____ **Phone:**(______)_____________

E-mail:____

Release Information From:

Greensboro Pediatricians 510 N. Elam Ave. Suite 202 Greensboro NC 27403

P: (336) 299-3831 F: (336) 299-1762

Please *securely* e-mail:

- ☐ Labs
- ☐ School Excuses
- ☐ Diagnosis

I authorize the disclosure of medical information for the patient named above. I understand that this authorization is voluntary and may be revoked in writing at any time, unless the medical records have already been disclosed. I understand that this authorization includes consent for information that may include substance abuse, mental health, and HIV/AIDS. I understand that this authorization is valid for 12 months from the date signed.

Patient/Parent Name____ **Date** _________________________

Patient/Parent Signature_____________________________________ **Relationship to Patient**___________________

Electronic Signatures: Delivery of this agreement by facsimile, email or other functionally equivalent electronic means of transmission constitutes valid and effective delivery.

Date Processed: _______________________

Processed by: _________________________

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