Authorization to Use or Disclose Protected Health Information

Patient Name:____

Address: ____

Date of Birth: _______________________

As required by the Privacy Regulations, Little Heroes, LLC may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

It is important that all health care providers work together. As such, we would like your permission to communicate with your child's primary care physician and any other healthcare provider necessary.

Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization.

If you prefer to decline consent no information will be shared.

- ☐ **You may inform my physician(s) and other providers**
- ☐ **I decline the right for you to inform my physician(s)**

Physician's Name: ____

Clinic: ____

Address: ____

Phone: ________________________________

Providers's Name:____

Clinic: ____

Address: ____

Phone: ________________________________

Providers's Name:____

Clinic: ____

Address: ____

Phone: ________________________________

Signature(s)____**Date:**_______________