Jackson Pediatrics

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Authorization for Use and Disclosure of Protected Health Information

_____ _____
Patient's Name Date of Birth

I hereby consent and authorize: **Jackson Pediatrics**
P.O. Box 1029
Jackson, WY 83001

Phone: 307-733-4627
Fax: 307-733-5184

Please choose one:	**Information requested:**	**Purpose:**
☐ To release to ☐ To receive from ☐ To receive from and release to	☐ All records ☐ Labs and imaging ☐ Other (specific dates, record types, etc): _____	☐ Referral ☐ Changing provider ☐ Moving ☐ Self ☐ Other: _____

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

_____
Signature of Parent/Guardian Date

_____
Signature of Witness Date