Uptown Pediatrics
Authorization for Release of Protected Health Information

Patient Name _____ Date of Birth _____

I _____, give Divya Hoon, MD at Uptown Pediatrics permission to:
Patient or guardian if patient is a minor

____contact
____receive
____disclose

information to/from _____ at
Name
_____ to help guide my/my child's psychiatric
Contact Information
treatment. This includes telephone, email, and paper correspondence.

I understand that state and federal privacy laws protect my records. My records can be released only if I give my written permission or if the law allows it. If I refuse to sign or cancel this release, I may not be eligible to receive the service I am requesting. I may cancel this consent with written notice at any time, but this written notice will not affect information the agency has already requested or released.

_____ _____
Patient or child's name Date

_____ _____
Patient or guardian signature (if child is a minor) Parent or guardian name