Angels Pediatrics, Inc.
Enas F. Attia, M.D.
1515 E. Alluvial Ave., Suite 105
Fresno, CA 93720-3832
Phone: (559) 322-5515 Fax: (559) 322-5915

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____/_____/_____

1. I authorize the use or disclosure of the above named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure;

From: _____

_____

Phone: (____) _____-_____ Fax: (_____) _____-_____

To: Angels Pediatrics, Inc.
1515 E. Alluvial Ave., Suite 105
Fresno, CA 93720-3832
Phone: (559) 322-5515 Fax: (559) 322-5915

3. The type and amount of information to be used or disclosed is as follows:

___ Problem list
___ Medication list
___ List of allergies
___ Immunization record
___ Most recent history and physical
___ Laboratory results from (date) ___/___/___ to (date) ___/___/____
___ Radiology and imaging reports from (date) ___/___/___ to (date) ___/___/____
___ Consultation reports from (physician name) _____
_X_ Entire Record
___ Other _____
_X_ copy sent to Physician's (no charge) ___ personal copies ($25.00)

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when than law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____ If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information used or disclosed, as provided in CFR 164.524, I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact the health information privacy officer.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient Signature of Witness

Form Faxed on: _____ By: _____