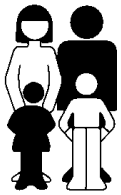

PHILADELPHIA HEALTH ASSOCIATES – PEDIATRICS, PC

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize PHILADELPHIA HEALTH ASSOCIATES – PEDIATRICS, PC to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits PHILADELPHIA HEALTH ASSOCIATES – PEDIATRICS, PC to use and/or disclose to _____
PERSON OR ENTITY TO RECEIVE THE INFORMATION (I.E. SCHOOL, DAYCARE, CAMP, ETC.)
the following individually identifiable health information: medical exam, diagnoses, treatment, immunization records, or _____

_____

_____

This authorization will expire one month after signing.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that PHILADELPHIA HEALTH ASSOCIATES – PEDIATRICS, PC has acted in reliance upon this authorization. My written revocation must be submitted to PHILADELPHIA HEALTH ASSOCIATES – PEDIATRICS, PC's Privacy Officer at 2085 North 63rd Street, Philadelphia, Pennsylvania 19151.

Signed by: _____ _____
SIGNATURE OF PARENT OR LEGAL GUARDIAN — RELATIONSHIP TO PATIENT

_____ _____
SIGNATURE OF PARENT OR LEGAL GUARDIAN — RELATIONSHIP TO PATIENT

_____
SIGNATURE OF PARENT OR LEGAL GUARDIAN