HEALTHY PEDIATRICS AT OLD BRDIGE, LLC

PERMISSION TO SHARE PROTECTED HEALTH INFORMATION FOR COORDINATION OF CARE

Here at Healthy Pediatrics at Old Bridge, LLC, we may disclose health-related information to a relative, close personal friend or any other person you identify as being involved with the care of your child/children. Please provide us with the names of those individuals who are involved with your child/children's care, with whom we may share their protected health information with in order to coordinate their care.

Name of individual	Relationship	Telephone#
Name of individual	Relationship	Telephone#
Name of Individual	Relationship	Telephone#
Name of Individual	Relationship	Telephone#

I understand that if I wish to revoke permission to release protected health information to any or all of these individuals, it will be my obligation to notify Healthy Pediatrics at Old Bridge, LLC of this decision.

Patient's name (print):_____ DOB_____/_____/_____

Signature of patient/parent/legal guardian:_____

If other than patient, please indicate relationship/authority:_____

Date:_____