KIDS CHOICE PEDIATRICS
Request to Send Protected Health Information to a Third Party

Patient's Name: _____ Date of Birth: _____

I request that **Kids Choice Pediatrics** send a copy of my child's protected health information (PHI), described below, to the following individual:

☐ Mail Name: _____

Street
Address: _____

City
State, Zip: _____

☐ Email Email Address: _____
Please Print Clearly (If we cannot read your email address, we will not send your records.)

Please be advised that our email is not encrypted and may therefore be at risk of being accessible by unauthorized individuals. By checking the box below, you are acknowledging that you have been made aware of these risks and give your permission for this office to email your protected health information to the email address you have provided above.

☐ I acknowledge that I have been notified of the risk of unencrypted email.

Description of Protected Health Information to be disclosed:

☐ Healthcare information relating to the following treatment, condition, or dates of service:

_____

_____

☐ All healthcare information

☐ Other: _____

_____

_____

Signature of Parent: _____ Date: _____

Printed Name:_____

Relationship to Patient: _____