JOHN D. OSTERMAN, M.D.
PEDIATRIC NEUROLOGY, P.A.
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AUTHORIZATION TO REQUEST & DISCLOSE HEALTH INFORMATION

I authorize JOHN D. OSTERMAN, MD PEDIATRIC NEUROLOGY, PA to request and/or disclose a copy of the specific health and medical information described below regarding:

NAME OF PATIENT: _____

DATE OF BIRTH: _____ **MALE/FEMALE**

Requested/released information:

_____

_____

_____

_____

FROM/TO: _____

FAX #: _____

For the purpose of: Treatment

If we are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization
- You may inspect a copy of the protected health information to be used or disclosed
- You may refuse to sign this Authorization and
- We must provide you with a copy of the signed authorization

You have the right to revoke this authorization at any time, provided that you do so in writing and except that we have already requested or disclosed the information in reliance on this Authorization. Unless revoked earlier or otherwise indicated, this Authorization will expire 365 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.
I have reviewed and I understand this Authorization, I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

PARENT'S SIGNATURE: _____

DATE: _____

WITNESS: _____