PROTECTED HEALTH INFORMATION CONSENT
EFFECTIVE SEPTEMBER 2008
SPECIAL CIRCUMSTANCES AGES 14 AND OVER

PATIENT INFORMATION:

Last Name	First Name	Middle Initial		DOB
Address		City	State	Zip
Home Phone	Cell Phone			

PARENT/LEGAL GUARDIAN INFORMATION:

________________________________ ______________________ _____________________________
Name Phone Number Relationship

________________________________ ______________________ _____________________________
Name Phone Number Relationship

AUTHORIZATION FOR RELEASE OF INFORMATION: By listing any name you are herby permitting Lancaster Pediatric Associates, Ltd. to discuss and/or disclose the above Patient's personal protected health information with the individual(s) stated below until the Patient or Parent/Guardian inform Lancaster Pediatric Associates, Ltd. in writing that permission is no longer granted.

Name(s) and Relation

Name(s) and Relation

Patient Signature Date

Please date and initial if NO CHANGES

_________ ________ ________ ________ ________ ________ ________ ________ ________ ________
Date Initial Date Initial Date Initial Date Initial Date Initial