Center for Pediatric Medicine

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(203) 790-1808 (Fax)

New Fairfield Commons, 11 Route 37
New Fairfield, CT 06812
(203) 746- 3280
(203) 746-3423 (Fax)

Patient Authorization Form

Patient Name: ____ DOB: __________

This is to certify that I am 18 years of age or older and I authorize Center for Pediatric Medicine to share all of my protected health information (PHI) with my legal guardian(s) as listed below.

Check One Option: ☐ Yes or ☐ No

This is to certify that I am 18 years of age or older and I authorize Center for Pediatric Medicine to share all of my protected health information (PHI) with my legal guardian(s) as listed below **through online Patient Portal services**. *We assure all information is encrypted and stored securely.*

Check One Option: ☐ Yes or ☐ No

_____________________________________ _______________________

(Name of Parent/Legal Guardian) (Relationship to Patient)

_____________________________________ _______________________

(Name of Parent/Legal Guardian) (Relationship to Patient)

This authorization will remain in effect until I am no longer a patient of Center for Pediatric Medicine **OR** until the following defined date or event: _________________________________

I understand that I may revoke this authorization at any time for any reason.

_____________________________________ _______________________

(Patient Signature) (Today's Date)

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(**Patient's** Primary Phone Number)