Avilio E Muñoz MD
PEDIATRICS

Authorization to Use or Disclose Health Information & Authorized Person's Signature

Patient Name _____

1. I authorize Fernando J. Velasquez MD (if aplicable) to transfer my child (& children's) medical records and reports to **Avilio E Muñoz MD**.

2. I authorize, release & give permission to **Avilio E Muñoz MD** to request all & any medical records from any of my child (& children's) medical providers at any time.

3. I authorize **Avilio E Muñoz MD** the use or disclosure of the above named individual's health information.

4. I have read and understand Holistic Pediatrics Group LLC. DBA Avilio E. Munoz MD, **HIPAA Notice of Privacy Practices Revised Effective January 1, 2008**.

5. I understand that the information in the health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

6. The information identified above may be used by or disclosed to my insurance carrier, or other entity specified by me during my visit(s).

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing to **Avilio E Muñoz MD**. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the laws provide my insurer with the right to contest a claim under my policy.

8. I understand authorizing the use or disclosure of the information identified above is voluntary.

9. I hereby authorize **Avilio E Muñoz MD** to render medical evaluation and treatment to my child, the person, or me otherwise under my care.

10. I hereby authorize the release of medical information necessary to report a claim to my plan(s). **I have read & understand the Avilio E Muñoz MD Financial Policy**. I agree to assign insurance benefits to the **Avilio E Muñoz MD** practice whenever necessary. I also agree that if it become necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

_____ 01/01/2008

Signature of patient or legal representative **Date**

A copy of this signature is valid as the original