Healthy Roots Pediatrics
27 Hilliard Street, Manchester, CT 06040
Phone: 860-646-3903 Fax: 860-645-3492

HIPAA Privacy Authorization Form

Authorization for use or disclosure of Protected Health information

Patient Name: _____ Date of Birth: _____

Patient Phone Number: _____

I _____, hereby authorize the office of Healthy Roots Pediatrics to
(Patient Name)
use and/or disclose my protected health information to the following individual(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Check what we can share:

- ☐ Ability to make appointments
- ☐ Lab Results
- ☐ Routine Health Care
- ☐ Substance Abuse Records
- ☐ Communicable Infections
- ☐ Behavioral Health Records

☐ **I do NOT wish to share my health information**

_____

Signature of Patient Date