(866) 219-8595
99 E Main St, Ste 200, Franklin, TN 37064-4186
AsYouAre.com

CONSENT TO OBTAIN PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

Parent Name: _____ Phone:_____

Address:_____

I authorize:

As You Are
99 E Main St, Ste 200
Franklin, TN 37064-4186
Phone: 866-219-8595

To obtain my child's protected health information (as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") from my child's previous treating organizations, physicians, and clinicians for the purpose of providing further medical care. I authorize the release of my child's full medical record including, but not limited to: Medical History, Treatment Notes, Prescriptions, Immunizations, Laboratory/X-Ray Reports.

I understand that this authorization will expire one (1) year from the date on which it was signed. I understand I may revoke this consent at any time by contacting support@asyouare.com; however, that will not affect disclosures made in reliance on this Authorization. I understand that my child may receive care even if I do not consent to release their health records.

Parent/Guardian Signature:_____Date _____

Parent/Guardian Printed Name: _____