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:

Parent/Guardian Printed Name:

Date:

Support@asyouare.com
866.219.8595
www.AsYouAre.com

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