SEE Alternatives Pediatrics (a division of SEE Alternatives, LLC)

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Individual's Name: _____

Individual's Date of Birth: _____

I, the undersigned individual as parent/legal guardian of the above-mentioned individual, hereby voluntarily authorize SEE Alternatives Pediatrics to release the above-mentioned individual's medical records to the following email via encrypted PDF.

Email: _____

A password must be identified and used to open the PDF. The password cannot be emailed with the records and must be identified at the time the PDF is created. Please print your preferred password below. **The password must be 8 characters with a minimum of 1 upper, 1 lower, and 1 number or special character.** Please keep a copy of this for future reference.

Password: _____

_____ _____

Signature of Parent/Legal Guardian Date

_____

Print name of Parent/Legal Guardian