Kathleen Ennabi Pediatrics

Heritage Square

2529 Route 52, Suite 3

Hopewell Junction, NY 12533

(PLEASE LIST ANY DOCTORS AND/OR FAMILY MEMBERS WHO YOU WOULD WANT TO HAVE ACCESS TO YOUR MEDICAL RECORDS)

I hereby authorize you to disclose my PHI (protected health information to the following person(s) or entity(s):

NAME:

ADDRESS:

PHONE NUMBER:

NAME:

ADDRESS:

PHONE NUMBER:

NAME:

ADDRESS:

PHONE NUMBER:

I understand that I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.

Patient Name_____

Patient Signature_____

Date_____