Pediatric Associates

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AUTHORIZATION/CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____
Patient Address: _____
_____

By signing below, I hereby authorize Pediatric Associates to use or disclose information about my child(ren) (or another person whom I have the authority to sign) that is protected under federal law, for the sole purpose and time period described below. You may refuse to sign this authorization. Subject to certain exception, you have the right to inspect and copy the protected information.

PLEASE RELEASE:

_____ Entire Medical Records _____ Physical Form Only
_____ Records from _____ (Date) to _____ (Date)
_____ Immunization Record Only
_____ Hearing and Vision Record Only
_____ Other (Specify): _____

PLEASE RELEASE RECORDS TO:

_____ Parent(s)
_____ Physician's Office
_____ Insurance Company
_____ Other (Specify): _____

Records are to be mailed to the following:

Name: _____
Address: _____
Phone #: _____
Fax #: _____

REASON FOR REQUEST:

_____ Moving
_____ Changing Physicians
_____ Requested by Court
_____ Day Care
_____ Other (Specify): _____
_____ Insurance Purposes
_____ Referral
_____ Preschool
_____ School

This information about your child(ren) is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclose pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign the authorization.

_____ _____
AUTHORIZATION SIGNATURE OF PARENT/GUARDIAN **DATE**

BELOW OFFICE USE ONLY:
DATE MAILED: _____
DATE FAXED: _____
DATE PICKED UP: _____
DATE REVISED: July 2, 2013