

ABC Pediatrics Authorization to Use or Disclose Protected Health Information

Patient name: _____ Date of birth: _____

Previous name: _____

1. My Authorization

ABC Pediatrics, PLLC may use or disclose the following health care information (check all that apply):

- All health care information in my medical record (If age 13 or over, please see #2 for additional authorizations needed and the **patient's signature will be required**).
- Health care information in my medical record relating to the following treatment or condition:

- Health care information in my medical record for the date(s): _____

- Other (e.g., X-rays, bills)—specify date(s): _____

2. Uses and Disclosures Requiring Specific Authorization for Patients—Patient Signature **REQUIRED TO RELEASE**

****EXCLUDE THE FOLLOWING INFORMATION FROM THE RECORDS RELEASED BY CHECKING BOXES BELOW:**

- HIV/AIDS (age 14 or older)
- Sexually transmitted diseases (age 14 or older)
- Mental health or illness (age 13 or older)
- Drug and/or alcohol abuse (age 13 or older)
- Reproductive Care (age 14 or older)

Patient's signature is **required** on Page 2 if over age 13.

You may disclose this health care information to:

Name (or title) and organization or class of persons: _____

Address _____ City: _____ State: ____ Zip: _____

Reason(s) for this authorization to use or disclose my health care information (check all that apply):

- Legal
- Transfer to another Doctor
- Personal Use
- Insurance
- School

This authorization ends:

on (date): _____ or when the following event occurs: _____

If an expiration date or event is not specified above, this authorization ends 6 months after the date signed.

3. My Rights

1. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign an authorization form:

- to receive research-related treatment in connection with research studies **or**
- to receive health care when the purpose is to create health care information for a third party.

2. I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by **ABC Pediatrics, PLLC** in reliance on this authorization before it receives my written revocation. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form—a form is available from **ABC Pediatrics, PLLC** or
- Write a letter to **ABC Pediatrics, PLLC**

4. Protection after Disclosure. I understand that once my health care information is disclosed, the person or organization that receives it may redisclose it and that privacy laws may no longer protect it.

Legally authorized individual signature (or patient over 18) Date Time

Printed name (if signed on behalf of the patient) Relationship (parent, legal guardian, personal representative)

Minor patient's signature, if applicable Date Time