HIPAA Authorization to Use and Disclose Protected Health Information

Release of Information

Patient Name: _____

Patient Date of Birth: _____

I hereby authorize Every Child Pediatrics to release information as described below to:

Name of Individual/Organization to receive information: _____

Address: _____

_____

Phone Number: _____ Fax Number: _____

Email Address: _____

For the purpose of:

- ❑ Continuing Care/Treatment
- ❑ Legal
- ❑ Personal Use
- ❑ Insurance
- ❑ Coordination of Services
- ❑ Other (please describe): _____

Type of records:

- ❑ Entire Legal Medical Record
- ❑ Pertinent Legal Medical Records Only (includes provider progress notes and reports, lab/pathology reports, imaging reports)

Other records:

- ❑ Telephone Consults
- ❑ Immunization Record
- ❑ PFT Tests
- ❑ Radiology Images/Reports
- ❑ Clinical Care Navigator
- ❑ HIV/AIDS Records
- ❑ Billing Information
- ❑ Nurse Notes/Patient Cases
- ❑ *Behavioral Health Notes {*may require alternative consent}

- ❑ Other: _____

Dates of Services: Beginning: mm/dd/yyyy_____Ending: _____

Please note: The information to be released may include a diagnosis or reference to the following condition(s): behavioral health services/psychiatric care, acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV), drug and/or alcohol abuse, or sexually transmitted diseases.

Patient signature required to release these department specific records: Patients aged 15 years or older (and in special circumstances 12 years and older): Reproductive health including pregnancy and sexually transmitted diseases, HIV/AIDS, or drug/alcohol treatment information. Patient aged 15–17 years old: Behavioral health or psychiatric care information, well child checks.

Release/Delivery method:

- ❑ Mail
- ❑ In person pick up
- ❑ Verbal
- ❑ Fax
- ❑ Encrypted Email

I understand the following:

This authorization will automatically expire one year from the date signed below or the date the minor child becomes an adult under state law unless I request a date sooner than one year. I may choose to revoke this authorization at any time, except to the extent that action has already been taken to comply with it, by notifying Every Child Pediatrics, in writing, information disclosed pursuant to the authorization may be subject to redisclosure by the recipient and is no longer protected by the HIPAA Privacy Rule. I will be provided with a copy of this authorization upon the fulfillment of the request. Every Child Pediatrics will still provide treatment and seek payment for services provided, whether or not I sign this authorization. Every Child Pediatrics may charge for the copies of medical records.

Signature: _____Date: _____

- ❑ Parent or personal representative
- ❑ Power of Attorney
- ❑ Next of Kin Deceased
- ❑ Execution of Estate Date: _____

When required: Signature of Patient: _____Date: _____