

Authorization for Use and Disclosure of Protected Health Information

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____

Telephone: _____

Information To Be Released – Covering the Periods of Health Care

Healthcare Provider Releasing Information: _____

Please check type of information to be released:

History and Last Physical Exam Vaccination Record Growth Chart

Purpose of Request for Disclosure

Treatment or Consultation At the Request of the Patient Continued Medical Care
 Other, (specify) _____

Who and Where to Send / Release Information

Release to: _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. **Check One:** Yes No

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release. **Check One:** Yes No

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.

I authorize First Choice Pediatrics to use and disclose the protected health information specified above.

Signature: _____ Date: _____

Authority to Sign if not Patient: _____