Pediatric Associates of Mt Carmel

Established 1972

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ (Patient/Parent/Guardian) authorize Pediatric Associates of Mt. Carmel to release medical records to the following (name of school, daycare or other third party):

_____

_____

_____

Pediatric Associate of Mt. Carmel may disclose the following protected health information (specifically describe the information to be used or disclosed, such as date(s) of service, type of service, level of detail to be release, origin of information, etc).

_____

_____

The information will be used or disclosed for the following purpose:

_____

_____

If requested by the patient, purpose may be listed as "at the request of the individual". The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

This authorization shall expire on _____/_____/_____ (MO/DD/YR)

I understand that I am not required to sign this authorization and can refuse to sign it. The practice will not receive payment or other remuneration from third party in exchange for using or disclosing the PHI. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I acknowledge that I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My revocation must be submitted in writing to the Practice Manager/Privacy Officer, Jasmine Sandhu.

I understand that my child's treatment is not dependent on my agreement to release or withhold information.

_____

Signature of Patient (Over 18), Parent or Guardian **Relationship to Patient** **Date**

_____

Patient's Name **Patient' Date of Birth**

PATIENT/ PARENT/GURDAIAN TO BE PROVIDED WITH A SIGNED COPY OF THE AUTHORIZATION

Batavia
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Batavia, OH 45103

Eastgate
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