



Authorization for Use and Disclosure of Protected Health Information

I hereby authorize Lighthouse Pediatrics LLC to use and/or **receive / disclose** my protected health information as described below **to / from**

Patient Name: _____ DOB: _____ Phone number: _____

Address: _____

Purpose of release: _____

☐ Check here if Lighthouse Pediatrics is requesting your medical records **FROM** another physician.
Name of Physician Office _____ Fax# _____ (**Records can be faxed TO Lighthouse at 404-806-6688**)

☐ Check here if you are requesting medical records to be **SENT TO** another physician from Lighthouse Pediatrics.

I authorize the release of medical information as indicated below:

☐ I would like records sent via email to: _____. ** Please note, sending information via email is unencrypted and could expose your Protected Health Information (PHI) to security risks. The practice does take all measures possible to transmit any PHI in a secure format. I understand that in requesting information to be sent in this format, that I am releasing Lighthouse Pediatrics, LLC, from all liability and security risks associated with sending any PHI via email.

☐ I would like to pick up a copy of my records in the following format: ☐ Hardcopy ☐ Disk

☐ I would like records faxed to: (please indicate fax #) _____

☐ I would like records mailed to the address listed below in the following format: ☐ Hardcopy ☐ Disk

Type of Information to Be Disclosed

☐ Entire Medical Record ☐ Office Chart Notes ☐ Billing Statements

☐ Other _____

Patient Photo Consent & Release (Optional)

I consent for photographs and/or video images to be taken of my child by Lighthouse Pediatrics or a representative, with notice before recording/photographing. I understand the images may be used for marketing purposes, social media, or . I understand that I will not be paid a fee for any photographs or video images. I understand that no identifying information will be included with the image.

- 1) THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE
2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
3) I may revoke this authorization at any time by notifying Lighthouse Pediatrics, LLC in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
4) Lighthouse Pediatrics, LLC agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

Signature: _____

Date: ____/____/____

Name (Print): _____

Relationship to Patient: _____

Address for Records to be SENT: _____

(Please note, a parent/guardian must be listed on the patient's chart or have a power of attorney letter to receive records)

Expiration:

This authorization will expire 180 days from the date of signing or (insert date) _____.

OFFICE USE ONLY

Received and identity verified by (print and sign): _____ Date: _____