DUNWOODY PEDIATRICS

18 and older HIPAA Release and Consent

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Complete to permit the disclosure of information to Parent/Guardians if Patient is 18 years and older)
Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164

1. AUTHORIZATION (Must complete if authorizing release of information)

By signing this authorization, I authorize Dunwoody Pediatrics to use and/or disclose certain protected health information (PHI) about me to: _____

Name of Person/Entity **Receiving** Information:	Relationship to Patient: (if applicable)

2. EFFECTIVE PERIOD:

This authorization for release of information covers the period of healthcare from:

A:	☐	Start Date:	End Date:

****OR****

B:	☐	All past, present, and future periods

3. EXTENT OF AUTHORIZATION:

A:	☐	I DO NOT authorize the release of my health record.

****OR****

B:	☐	I authorize the release of my complete health record (including but not limited to records related to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

****OR****

C:	☐	I authorize the release of my complete health record with the exception of the following information:
		☐ Mental health records; ☐ Communicable diseases (including HIV and AIDS); ☐ Alcohol/drug abuse treatment; ☐ Other (Please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct;

5. This authorization shall be in force and effect for one (1) year from the date signed or_____, (date or event), at which time this authorization expires;

6. I understand I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage at the insurer has a legal right to contest a claim;

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization;

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient Signature:	Date:
Patient Printed Name:	Telephone #:

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