PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This authorization permits use and/or disclosure of the following individually identifiable health information about me or my child:

Office/Person to **RELEASE/SEND** records:

☐Priority Care Pediatrics, LLC
Phone: 816-412-2900 Fax: 816-412-2915

☐Name/Office: _____

Phone: _____

Fax/Email: _____

Office/Person **TO RECEIVE** records:

☐Priority Care Pediatrics, LLC
Phone: 816-412-2900 Fax: 816-412-2915

☐Name/Office: _____

Phone: _____

Fax/Email: _____

Records to be released:

☐Complete Medical Records ☐Immunization Records ☐Growth Charts
☐Laboratory/X-ray Reports ☐Mental Health Information ☐Hospital Records/1st visit notes for insurance
☐HIV/AIDS Test Results ☐Verbal Communication ONLY ☐Consultant/Other Physicians Reports
☐Other:

Specific Date Range: ALL Dates ____/____/____ to ____/____/____

Authorization Expiration Date: ____/____/____
(1 yr unless notes)

The information released will be used for the following purposes:

☐At the patient/guardian's request (guardian signature required)
☐Other: _____
☐Continuation of care (guardian signature not required)

I do not have to sign this authorization in order to receive treatment from Priority Care Pediatrics, LLC. In fact, I have the right to refuse to sign this authorization. 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 have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at the address of Priority Care Pediatrics below.

_____ Patient's Name

_____ Date of Birth

_____ Signature of Patient/Legal Guardian

_____ Relationship to Patient

_____ Print Name of Patient/Legal Guardian Signing Above

_____ Today's Date