



AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Revocation
Date Revoked: _____

Patient Name: _____ Medical Record No. _____

Address: _____

I authorize ABC Pediatrics, PC to use or disclose my child’s health information as described below.

1. **Type of information:** The type of information to be used or disclosed is as follows (check the appropriate spaces and include other information where indicated):

- ___ Entire medical record (all information)
- ___ Physician and Professional Consult Progress Notes
- ___ Diagnostic reports (lab, x-ray, etc.)
- ___ History and physical
- ___ Medication and treatment records
- ___ Immunization Records
- ___ Medical Summary
- ___ Other (Describe as specifically as possible):

2. **Recipient of information** - The information identified above may be used by, or disclosed to, the following individual(s) or organization(s):

Name: _____ Name: _____

Address: _____ Address: _____

Phone Number: _____ Phone Number: _____



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3. **Purpose of use/disclosure** - This information described on the previous page will be used for the following purpose(s):
- ____ Initiated at the request of the parent.
- ____ Transferring to local provider
- ____ Other (please describe): _____

Authorization Statements/Signatures:

4. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the HIPAA Privacy Rule may no longer protect the information.
5. I understand that ABC Pediatrics will not charge for copies of immunization records or medical summaries. We will charge \$5.00 for forms: 3231, 3300 or 3189 and \$10.00 for any form requiring a provider's review/signature: sports, camp, college or physical forms. There will be a \$30.00 charge for a copy of the full medical records of the first child and \$20.00 for each additional charge, payable on the day this form is signed. The fee will not exceed \$70.00 per family.
6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to ABC Pediatrics, PC. I understand that the revocation will not apply to information that has already been released in response to this authorization.
7. Unless I specify differently, this authorization will **expire in one year from date or** _____.
8. I understand that ABC Pediatrics, PC will not condition the provision of treatment or payment on the provision of this authorization.

Signature of Patient or Parent or Legal Guardian

Date

Print Name

Relationship to Patient