AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE AND SIGN

I. I, _____, hereby voluntarily authorize the disclosure of information from my health record. *(Name of Patient)*

II.	**The information is to be disclosed by:**	**And is to be provided to:**
	NAME OF FACILITY:	NAME OF PERSON/ORGANIZATION/FACILITY:
	ADDRESS:	ADDRESS:
	CITY/STATE:	CITY/STATE:
	PHONE:	PHONE: FAX:

III. The purpose or need for this disclosure is:

☐Further Medical Care ☐Attorney ☐School ☐Research ☐Other (Specify): _____

☐Personal Use ☐Insurance ☐Disability ☐Health Information Exchange:_____

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

- ☐ Immunization Record
- ☐ Growth Charts
- ☐ Last Well Child Check or Preventative Visit (Wellness)
- ☐ Office visits or referrals related to Chronic Conditions
- ☐ Office visits or referrals related to Behavior Health/ADHD Managements
- ☐ Diagnostic Labs or Imaging
- ☐ Referrals to specialists
- ☐ Entire Record

☐ Only the period of events from _____ to _____ ☐ Other (specify): _____

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment

☐ Sexually Transmitted Diseases ☐ Mental Health *(Other than Psychotherapy Notes)*

V. I understand that I may revoke this authorization in writing submitted at any time to the organization, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated.

_____

(Specify new date)

I understand that Peacock Pediatrics will not condition treatment or eligibility for care on my providing this authorization except if such care is (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party. I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164].

Signature of Patient or Personal Representative ***(State relationship to patient)***	Date
Signature of Witness	Date

PATIENT IDENTIFICATION

Name (Last, First, MI):_____ Date of Birth: _____