AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Revocation
Date Revoked:

Patient Name: ________________________ DOB:_______________ Account #:____________________

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):
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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: __________________________________

Fax Number: ______________________________ Fax 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 $20.00 for any form requiring a provider's review/signature: sports, camp, college or physical forms. There will be a $50.00 charge for a copy of the full medical records of the first child and $25.00 for each additional charge, payable on the day this form is signed. The fee will not exceed $75.00 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

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