Primary Pediatric Medical Group, Inc.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize:

_____
Name of Disclosing Party

_____
Address

_____
City State Zip

to disclose to:

_____
Name of Recipient

_____
Address

_____
City State Zip

Records and information pertaining to:

_____
Name of Patient

_____
Address

_____
City State Zip

_____
Date of Birth

_____
Primary Doctor

_____
Telephone

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _____(date).

REVOCATION: This authorization is also subject to written revocation by the patient/parent/guardian at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

REDISCLOSURE: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

SPECIFY RECORDS: Check the box, initial and/or sign to specify which type of information is to be disclosed.

MEDICAL INFORMATION _____(Initial)
PSYCHIATRIC INFORMATION _____(Signature)_____(Date)
DRUG/ALCOHOL INFORMATION _____(Signature)_____(Date)
RESULTS OF AN HIV TEST _____(Signature)_____(Date)
GENETIC RECORDS _____(Signature)_____(Date)
OTHER HEALTH INFORMATION _____(Initial and specify below)

_____

The recipient may use the health information authorized on this form for the following purposes: _____

Please circle reason for request: Change in insurance coverage; Child moving to an "adult" doctor; Moving from the area; Dissatisfied with the Practice; Other_____

A copy of the authorization is as valid as the original.

Signature: _____Relationship (if not patient): _____ Date: _____