35 Goodwin Drive
Festus, MO 63028
Phone: (636) 933-4141
Fax: (636) 931-7007

1309 Maple Street
Farmington, MO 63640
Phone: (573) 756-4343
Fax: (573) 756-7191

Notice: As set for the more fully in our Notice of Privacy Practices, we are required by law to obtain your authorization for any use or disclosure of your health information for purpose other than treatment, payment or health care operations. In our Notice of Privacy Practices, we provided you information about how Kidz Biz Pediatrics can use or disclose your health information. You have a right to review our Notice of Privacy Practices before signing this Authorization.

I hereby authorize Kidz Biz Pediatrics to: **____disclose/release to ____obtain from**
(We receive and/or send records via fax or email)

_____
Name of Physician, Practice, Hospital or Entity

_____
Address

_____
Phone Email and/or Fax

certain protected health information (PHI) of:

Patients Name:_____ Date of Birth: _____

Please check the appropriate individually identifiable health information to be released

___Entire Record
___Most Recent History and physical
___Immunization Record
___Laboratory results Dates from_____to_____
___X-ray and/or imaging reports Dates from_____to_____
___Consultation reports
___Diagnosis Letter for IEP/504 Plan/Other
___Other _____

I understand that this authorization may include information relating to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Syndrome (HIV) infection, Psychiatric Care, Behavioral or mental health services, Treatment for alcohol and /or drug abuse and Genetic Testing.

I understand that this information disclosed may be subject to re-disclosure by the recipient and no longer be protected by Kidz Biz Pediatrics. Kidz Biz Pediatrics and its staff are hereby released from any legal responsibility or liability for disclosure of the below information to the extent indicated and authorized herein.

This authorization will expire on_____or 90 days from the date set forth below. In accordance with the procedures set forth in the Practice's Notice of Privacy Practices, when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure 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 listed above has acted in reliance upon this authorization. My written revocation must be submitted to the practice above.

I acknowledge and understand that Kidz Biz Pediatrics may not condition enrollment or eligibility for benefits upon my granting this authorization, unless the authorization is for their eligibility or enrollment determinations relating to me or for its underwriting or risk rating determinations; and the authorization.

Signature of Parent, Patient or Legal Guardian_____

Printed Name of Parent, Patient or Legal Guardian_____

Date_____Relationship_____

Purpose for disclosure_____

Note to Recipient: This information has been disclosed to you from records whose confidentiality is protected by Federal and State laws (including HIPAA) and prohibits you from further disclosure without the written consent of the person to whom it pertains. **A copy of this form will be filed in the above named patient's PHI**