Pediatric Associates of Westmoreland

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Transferring In

I _____ authorize _____

To use or disclose health information as described below regarding my treatment, hospitalization, and/or care for my condition, which may include psychiatric impairment, drug abuse and/or alcoholism, sickle cell anemia, sexually transmitted disease or Acquired Immunodeficiency Syndrome (AIDS) or tests for or infections with Human Immunodeficiency Virus (HIV).

Patient's Name: _____ Birthdate:_____

Information to be disclosed to: Pediatric Associates of Westmoreland

____555 West Newton St Suite 10 Greensburg, PA 15601 Phone: 724-832-7045 Fax: 724-832-9165

____27 North Thompson Lane Suite A, Irwin, PA 15642 Phone: 724-864-1830 Fax: 724-864-1839

____508 North Church Street Suite 101, Mt. Pleasant, PA 15666 Phone: 724-547-4547 Fax:724-542-4506

____205 North Carnegie Ave, Suite A, Connellsville, PA 15425 Phone 724-603-2757 Fax : 724-603-2760

For the purpose of: _____

Description of information to be disclosed: Date of Service:_____

( ) Entire Record

( ) Other:

_____

I understand that the information described above could possibly be redisclosed by the recipient and no longer protected by the federal privacy regulations. The recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

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 as described in the Pediatric Associates of Westmoreland Notice of Privacy Practices. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand that the revocation will not apply if the authorization was related to my obtaining insurance coverage, as the insurer has the right by law to contest a claim or insurance policy. Unless otherwise revoked, this authorization will expire on:_____. If I fail to specify a date or event, this authorization will expire in 90 days.

I understand that Pediatric Associates of Westmoreland may not condition treatment, payment, enrollment or eligibility for benefits on signing this authorization except in the case of research related treatments.

_____ _____

Signature of Patient/Customer or Legal Representative & Relationship Date

_____ _____

Signature of Witness Date

03/14/2017