CARING HANDS PEDIATRICS

www.caringhandspediatrics.com

Authorization for Care and Release of Protected Health Information

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We believe it is best for your child to be with a parent or legal guardian at every visit. However, we realize that this is not always possible. If you would like to give permission to another individual to bring your child for care or treatment, please complete the information below. Please be aware that this individual will also have access to your child's personal health information during the visit**.**

If you would like any information excluded, it must be documented below.

PATIENT INFORMATION

Last: _____ First: _____Middle:_____

Address: _____

Date of Birth: _____/_____/_____ Phone ( ) _____

I _____ parent of _____ give permission for the individual(s)
(Parent's name) (Child's name)
named below to bring my child in for care and treatment by ***Caring Hands Pediatrics and/or Staff***. I am aware that protected health information, including but not limited to, insurance, address, phone number, test results and healthcare information may be discussed at this time.

Name of Person: _____ Name of Person: _____

Relationship to Patient: _____ Relationship to Patient: _____

Phone: ( ) _____ Phone: ( ) _____

Please exclude the following information: **Please exclude the following information:**

_____ _____

_____ _____

I understand that:

- **I may revoke this Authorization at any time, in writing. My revocation will not apply to information already retained, used or disclosed in response to this Authorization.**
- Unless the purpose of this Authorization is to determine payment of a claim or benefits, the provision of treatment or payment for my care may not be contingent upon my signing this Authorization.
- Information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.
- **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMNICABLE DISEASE OR A NONCOMMUNICABLE DISEASE UNLESS OTHERWISE EXCLUDED.**
- The information Authorized for release also may include protected health information related to mental health.
- The information/record is protected by the HIPAA Privacy Rule.
- **This Authorization will expire at the end of the calendar year of my signature below unless an earlier termination date is specified.** _____

Signature of Parent _____ Date_____

Relationship to Patient _____

You have the right to receive a copy of signed authorizations upon request.