AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Read entire document before signing

This authorization gives Pediatric Associates of Plymouth, Inc. permission to use and/or disclose health information about you.

Right not to sign. You may refuse to sign this authorization. Refusal to sign this authorization will not affect your ability to obtain treatment by Pediatric Associates of Plymouth, Inc., except in the case of health care that is solely for the purpose of creating health care information for disclosure to a third party (for example, a pre-employment physical).

Right to revoke. You may revoke this authorization at any time except to the extent that we have relied on the authorization. To revoke this authorization, you must submit a written revocation to our privacy officer at the following address:

Pediatric Associates of Plymouth, Inc.
Attention: Privacy Officer
3031 Walton Road C101,
Plymouth Meeting, PA 19462

Authorized uses and disclosures

Please print

1. Patient(s) name(s) _____

   Patient(s) address _____

2. Requested health information (Describe the requested PHI in specific terms, "All medical records" is sufficient for disclosure)

_____

_____

☐ I am ☐ I am not authorizing the release of medical records containing information about mental health, drug or alcohol treatment, HIV, ADD/ ADHD, behavior and/or neurological disorders.

3. Identity of disclosure: Provide the name or other specific identification of the person(s) or class of persons authorized to disclose the covered information.

_____

_____

_____

_____

4. Authorized action: ☐ disclosures (check box)

5. Identity of recipient: Provide the specific identification of the person(s) or class of person(s) to whom the covered entity may disclose the covered information.

_____

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_____

6. Reason for transfer ("At request of individual" is sufficient for disclosure initiated by the patient).

_____

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7. Expiration of authorization: Provide a date or event that relates to the patient(s) or the purpose of the use and/or disclosure ("1 year from now" is sufficient for disclosure).

_____

_____

Any patients 18 years of age, or older, must sign the transfer form. We cannot release records for these patient to parents, without the written request of the patient(s) involved.

I have read and understand this authorization, and authorize use and disclosure of health information about the named patient(s) as described in this authorization.

_____ _____

Signature of patient (or personal representative) Date

_____

Printed name of personal representative (if applicable)

_____

Relationship to patient(s)