

**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).

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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)