Authorization for Use and/or Disclosure
Of Protected Health Information

Patient Information (Please Print)

Last Name	First Name	Middle Initial		Gender
Address	City	State	Zip Code	Phone Number
Date of Birth	Social Security Number (Optional)		Email Address (Optional)	

Please check/specify the information which you want to be used and/or disclosed as a result of this authorization. *Failure to specify (including dates) will render this Authorization invalid.*

Dates of Treatment/Particular Illness Requested:_____

- ☐ History and Physical Exam
- ☐ Progress Notes
- ☐ Lab Reports
- ☐ X-ray Reports
- ☐ Other:_____
- ☐ **ALL**

Purpose for Disclosure

- ☐ Medical Care
- ☐ Attorney/Legal
- ☐ Personal
- ☐ Insurance
- ☐ Disability/SSI
- ☐ Other

Disclose Records To:	
Name	_____
Company	_____
Street Address	_____
City, State, Zip	_____
Telephone Number	_____

The Authorization will expire 60 days after the date below, or sooner by my choice, in which case, Authorization will expire on_____, or_____(event) occurs. This Authorization may be revoked at any time to the extent that use and/or disclosure has not already occurred prior to your request for revocation. In order to revoke the Authorization the individual/parent/legal guardian must submit a request in writing.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the Federal privacy regulations. Pediatric Care, Inc. will not condition treatment or payment on the execution of this Authorization.

I, the undersigned, hereby authorize Pediatric Care to use and/or disclose information from my (or give relationship) _____ medical or financial record as specified above. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above mentioned entity(s).

There is no charge for medical records if copies are sent to facilities for ongoing care or follow-up treatment. For billable requests, the requestor will be notified of the cost prior to duplication. HIPAA allows healthcare providers 30 days to process record requests with an acceptable extension period of 30 days when required. Pediatric Care, Inc. strives to provide records more timely, however occasionally the full 30 days are required due to record availability (e.g. offsite storage etc).

Signature:_____Date:_____/_____/_____ □ Patient □ Parent □Legal Guardian*

The above statements must be signed and dated to be valid. If the patient is an emancipated minor or 18 years of age, he/she is required to sign the Authorization.
If Pediatric Care requests this Authorization for its own use or disclosure, a copy of this Authorization must be provided to the individual completing this form.

- *Documentation regarding guardianship must be provided in order to comply with the above request.*

Pediatric Care, Inc.

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