Premier Pediatrics

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Authorization for Use or Disclosure of Medical Records of:

Patient Name_____Date of birth_____Sex_____
Nickname if used_____
Name of Parent/Legal guardian_____
Street Address_____City_____State_____Zip_____
Home phone_____Cell phone_____Work phone _____

Name of practice to disclose records_____
Address/City/State/ Zip (if different from above)_____
Phone_____Fax_____

My authorization:

You may use or disclose the following health care information (Circle all that apply)

- Only copies of immunization record, growth charts, last physical or well baby exam and any important data, excluding confidential information.
- All my health information maintained by the above practice.
  (If adolescent or emancipated minor, they must sign for release of confidential information below.)
  (Circle "include" or "exclude" for each of the following. If not circled, information will not be included.)
  Include or Exclude: My health information related to drug abuse and/or alcohol abuse.
  Include or Exclude: My health information related to HIV/AIDS
  Include or Exclude: My health information related to psychological or psychiatric conditions, including psychotherapy notes.
- My health information relating to the following treatment or condition_____
- My health information for the following date(s):_____
- Other_____

You may disclose this information to:

Name or title of organization_____
Address_____City_____ State____Zip_____

Reason for this authorization (Circle all that apply)

- At my request
- Other (specify)_____

My Rights

I understand I do not have to sign this authorization in order to get health care benefits from Premier Pediatrics for treatment, payment, or health care operations. However, a signature will be required if I am asked to take part in a research study, for marketing purposes or to receive health care when the purpose is to create health information for a third party.

I understand that I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are to fill out a revocation form available from the office, or by writing a letter to this office. I understand that once this office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name of patient or legally authorized individual Relationship (self, parent, legal guardian, etc.)

This authorization ends after one year from the date on this form, unless revoked in writing prior to one year.