Patient Authorization for Use and Disclosure of Protected Health Information

Patient Name: _____ Date of Birth_____

I HEREBY AUTHORIZE:

Name: _____
Address: _____
City/State/Zip: _____
Phone: _____
Fax: _____

TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO:

Name: _____
Address: _____
City/State/Zip: _____
Phone: _____
Fax: _____

Specifically describe the information to be used or disclosed, such as complete medical record, date(s) of service, type of services, level of detail to be released, etc.:

_____

For the purpose of:

___ Changing Physicians ___ Consultation ___Insurance ___School ___Research __At request of individual

___ Legal (specify): _____

___ Other (specify): _____

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of information. This expiration date of this authorization is _____ (Note: Authorization will expire 90 days from the date signed unless otherwise stated).

I do not have to sign this authorization in order to receive treatment from Brentwood Pediatrics. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at 1600 South Brentwood Boulevard, Suite 100, Brentwood MO, 63144.

Signed by_____ _____

Patient/Parent/Legal Guardian | Relationship to Patient

_____ _____

Print name of Patient/Parent/Legal Guardian | Date