

PEDIATRICS AT THE MEADOWS PC

Authorization to Use or Disclose My Health Information

Patient name: _____ Date of birth: _____

Previous name: _____

I. My Authorization

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

- All my health information maintained by the above-named practice
- My health information relating to the following treatment or condition: _____
- My health information for the date(s): _____

I specifically authorize disclosure of the following conditions (check all that apply):

- Drug abuse
- Alcohol abuse
- HIV/AIDS
- psychological or psychiatric conditions, including psychotherapy notes

You may disclose this health information to:

Name (or title) and organization _____

Address: _____ City _____ State _____ Zip _____

Reason(s) for this authorization (check all that apply):

- At my request
- Check here only when _____ requests the authorization for marketing purposes
- Check here only if this authorization involves the sale of protected health information
- Check here only when _____ will get anything of value for providing health information (other than copying costs)
- Other (specify) _____

This authorization ends*:

- On (date): _____
 - When the following event occurs: _____
- *If no end date is provided, this authorization will expire one year from the date of signing*

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment or eligibility for benefits). However, I do have to sign an authorization form:

- To take part in a research study;
- or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I revoke this authorization, it would 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:

- Fill out a revocation form. The form is available from the office;
- or
- Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may be able to redisclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature

Date

Time

Printed Name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative, etc.)