PEDIATRIC ASSOCIATES, PSC

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) I authorize Pediatric Associates to release all medical records and information, oral or written, including substance abuse diagnosis and treatment records and HIV-related records concerning any medical treatment or evaluations that I have received from Pediatric Associates, including all records of other medical providers in their possession to the following for the purpose of keeping them informed of my health care status and to obtain payment on my behalf.

Please release to me:

_____	_____	Self_____
Printed Name	Date of Birth	Relationship

My phone number is: _____

Information can also be released to:

_____	_____	☐ phone ☐ portal access
Printed Name	Relationship	

_____	_____	☐ phone ☐ portal access
Printed Name	Relationship	

I also understand that information on Advance Beneficiary Notice (ABN) is available to me in this office. I can get more information on an ABN and how to write one by asking the health care provider I see today.

This authorization shall remain in effect until I am no longer a patient at Pediatric Associates unless I revoke it. I understand that I have the right to revoke this authorization at any time except to the extent that information has already been released based on this authorization. I also understand that this revocation must be provided in writing to the Privacy Officer at Pediatric Associates.

_____	_____
Signature of Patient	Date