

**PEDIATRIC ASSOCIATES, P.S.C.**  
**AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION**

Pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Regulations, 45 CFR §164.508, I hereby authorize **Pediatric Associates, P.S.C.** (the "Practice") to release all medical records and information, whether oral or written, including, but not limited to treatment notes, visit history, lab reports, diagnostic evaluations, outpatient records, films of x-rays, MRIs or PET scans, genetic testing, mental health diagnosis and treatment records, prescription records, substance abuse diagnosis and treatment records, and HIV-related records concerning any medical treatment or evaluations that I, \_\_\_\_\_, have received from the Practice, including all such records of other medical providers in the possession of the Practice, to:

\_\_\_\_\_

for the purpose of keeping such individuals informed of my health care status and to obtain payment on my behalf.

A photocopy of this Authorization shall be as valid as the original authorization.

This authorization, unless revoked earlier, shall remain in effect for until I am no longer a patient of the Practice. I understand that I have the right to revoke this authorization at any time except to the extent the Practice has already acted upon it as a result of this authorization. I further understand that any revocation must be provided in writing to \_\_\_\_\_, the Practice's Privacy Officer.

I understand that I have the right to refuse to sign this authorization and that the Practice will not condition treatment on the provision of this authorization.

I also understand that when information is used or disclosed based on an authorization, the information may be re-disclosed by the recipient and no longer protected by HIPAA.

By my signature below, I acknowledge receipt of a signed copy of this authorization.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

Patient's DOB: \_\_\_\_\_ Patient's SSN: \_\_\_\_\_