Authorization for Use and Disclosure of Protected Health Information
Patients 18 yrs of age and older

NAME_____ **DATE OF BIRTH**____/____/____

MAILING ADDRESS _____

CELL PHONE NO._____**EMAIL ADDRESS**_____

EMERGENCY CONTACT NAME AND PHONE_____

By signing this form, I am consenting to allow Pedi-Care to use and disclose my protected personal health history to carry out treatment, payment and health care operations. This authorization also permits Pedi-Care to disclose health information about me to the individuals listed below, including appointment reminders, insurance items, laboratory test results, and any issues pertaining to my clinical care. With this consent, Pedi-Care may call, email, or mail the individuals indicated below and leave a message on voice mail or in person in reference to my health care.

INDICATE ONE ONLY:

☐ I only want my medical information released to myself (use only my contact information listed above)

☐ I give Pedi-Care and staff authority to release medical information regarding my care to the parties listed below:

1. _____
(Name) (Relationship to patient)

_____
(Address) (Phone) (email)

2. _____
(Name) (Relationship to patient)

_____
(Address) (Phone) (email)

I understand that when my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing (if submitted to Pedi-Care's Privacy Officer) except to the extent that the practice has acted in reliance upon this authorization. I understand that I do not have to sign this authorization in order to receive treatment from Pedi-Care.

_____ _____
(Signature of Patient) (Printed Name) (Date)