PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE PRACTICE FROM ANOTHER OFFICE

MEMO TO:

_____
Name of Doctor, Practice, Hospital, Clinic or other Health Care Provider

_____
Address *City* *State* *Zip*

MEMO From:

_____ _____ _____
Name of Patient information is being Requested For *Date of Birth* *Social Security #*

_____
Address *City* *State* *Zip*

Dear Provider Office or Medical Facility:

_____
Date of Request

My doctor has provided this HIPAA compliant request/authorization form in order to assist me in requesting you to forward copies of my medical record.

By signing this authorization, I request and authorize you to use and/or disclose certain protected health information (PHI) about me to:

Springville Pediatrics
25 East Main Street
Springville, NY 14141
Phone (716) 592-2832
Fax (716) 592-4452

This authorization permits you to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

_____

_____

_____

The information will be used or disclosed for the following purpose:

_____

This authorization will expire on: _____/_____/_____
Expiration Date or Defined Event

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 except to the extent that your office acted in reliance upon this authorization. My written revocation must be submitted to your Privacy Officer at the address listed above.

Signed by: _____ Date: _____/_____/_____

*Signature of Patient (*if patient between the age of 12 and 18 both patient and parent must sign)*

_____ _____ _____/_____/_____

Signature of Parent or Legal Guardian *Relationship to Patient* *Today's Date*

_____ _____/_____/_____

Print Patient's Name *Date of Birth*

25 E. Main Street, Springville, NY 14141 | Phone (716) 592-2832 | Fax (716) 592-4452