Springville Pediatrics

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

By signing this authorization, I authorize Springville Pediatrics, LLP (The Practice) to use and/or disclose certain protected health information (PHI) about me to:

_____

Name of entity to receive this information *Address*

This authorization permits The Practice 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

The Practice *(check one)* ❑will ❑will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

The Practice *(check one)* ❑will ❑will not charge a fee for this; Estimated Cost: _____.

I do not have to sign this authorization in order to receive treatment from The Practice. In fact, I have the right to refuse to sign this authorization.

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 the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at The Practice 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*

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION